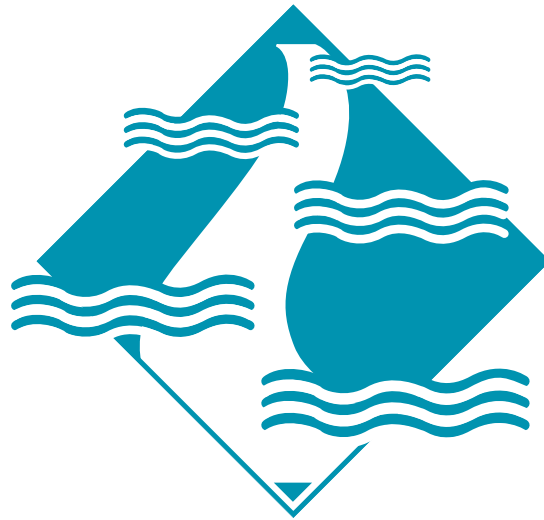


MANY STREAMS



≡ MAKE A RIVER ≡

Proceedings of the
National Conference on
Community Systems-Building
and Services Integration

September 14-15, 1997 ♦ Doubletree Hotel ♦ Rockville, Maryland

Sponsored by: U.S. Department of Health and Human Services
Health Resources and Services Administration
Maternal and Child Health Bureau
Bureau of Health Professions
Bureau of Primary Health Care
HIV/AIDS Bureau





Many Streams Make a River

Proceedings of the National Conference on Community Systems-Building and Services Integration

September 14–15, 1997

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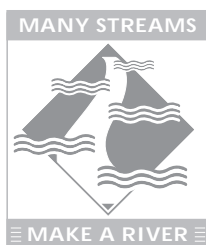
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National Conference on Community
Systems-Building and Services Integration

Table of Contents

Part I—Conference Overview 1

Part II—Workshop Summaries 10

Concurrent Sessions I: Showcase of Innovative Programs 10

Hale Empowerment and Revitalization
Organization 10

National Native American AIDS Prevention
Center 11

Hillsborough County Health Care Plan 12

Local INvestment Commission (LINC) 14

Rural Partnership for Children 15

Growing Into Life Task Force 16

Healthy Families Partnership 18

Concurrent Sessions II: Technical Assistance Workshops 19

Asset-Based Community Development
Institute 19

Parent Training Program: Selecting the
Best Program and Staff Training for
Your Community 20

Coalition for Healthier Cities and
Communities 22

The DELTA Project 23

Harrison Institute for Public Law 24

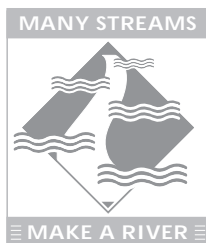
Health Systems Research, Inc. 25

Together We Can Initiative 26

National Training and Technical
Assistance Center 27

Table of Contents

Replication: Increasing the Return on Social Investment	28
Maternal and Child Health National Center for Cultural Competence	30
Concurrent Sessions III: Showcase of Innovative Programs	31
Baltimore City Healthy Start Program	31
Mercy Children's Health Outreach Project	32
Michigan Public Health Institute	34
Ready 2 Work: Family-Centered Community Transition Services	35
Comprehensive Community Health and Services Program of Project Vida	36
Vermont's Comprehensive, Community- Based System of Care for Children and Adolescents	37
Group Presentations	39
<i>Presented in Concurrent Sessions I and III.</i>	
Serving Children with Special Health Care Needs and Their Families: Washington State Systems-Building and Services Integration Activities	39
Enhancing Access and Capacity Through Nontraditional Providers: Wisconsin State Systems-Building and Services Integration Activities	41
Parent-Professional Collaboration Models	45
Part III—Appendices	48
Agenda	49
Steering Committee Members	58
Participants List	61



National Conference on Community
Systems-Building and Services Integration

Part I

Conference Overview



Introduction

On September 14–15, 1997, the Health Resources and Services Administration (HRSA) hosted the National Conference on Community Systems-Building and Services Integration in Rockville, Maryland.

The four bureaus of HRSA—the Maternal and Child Health Bureau (which took the lead), the Bureau of Primary Care, the HIV/AIDS Bureau, and the Bureau of Health Professions—united to convene the conference to showcase communities that are engaged in planning, implementing, and sustaining integrated service systems.

Communities are telling the many public- and private-sector agencies that fund community programs that the time has come to coordinate the numerous but isolated funding streams that exist for health, education, early intervention, mental health, and social services programs. Funders have heard that message, and this conference served as evidence of a sincere commitment to coordinate efforts in support of community systems development.

Cosponsors of the meeting, in addition to the four HRSA bureaus, included the Administration on Children, Youth and Families, U.S. Department of Health and Human Services, and the Office of Juvenile Justice and Delinquency Prevention, U.S. Department of Justice, as well as 18 private-sector agencies and organizations (Figure 1). The conference proceedings were produced with the support of a grant from the W.K. Kellogg Foundation.

The conference steering committee unanimously agreed on *Many Streams Make a River* as the conference theme and title. The image of many small streams coming together to form a mighty river vividly conveys the potential power of the movement toward community systems-building and services integration.

Figure 1
National Conference on Community Systems-Building and Services Integration Cosponsors

American Academy of Pediatrics	Institute for Educational Leadership	Together We Can
Association of Maternal and Child Health Programs	Michigan Public Health Institute	U.S. Department of Health and Human Services, Administration on Children, Youth and Families, Child Care Bureau
Center for the Improvement of Child Caring	National Center for Education in Maternal and Child Health	U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention
City MatCH	National Council of Community Hospitals	W.K. Kellogg Foundation
Coalition for Healthier Cities and Communities	National Healthy Mothers, Healthy Babies Coalition	Washington Business Group on Health
The DELTA Project	National Parent Network on Disabilities	
Family Voices	The Robert Wood Johnson Foundation	
Grantmakers in Health		
Healthy Futures		

Background

Historically, communities have developed strategies to address their needs and identify their assets. Examples include the development of the public school system, the emergency medical services and other public safety systems, and the health care delivery system. Over the past 50 years, however, the health care system in the United States has evolved into a maze of weakly connected services that frequently duplicate one another.

Agencies and institutions that promote, protect, and support the health, growth, and development of America’s children, youth, and families have historically targeted the needs of individual children and families. However, the kinds of support that children and families need are often broad in scope and complex in their impact on health and well-being. Existing categorical programs, while vital, have not allowed for the integration of service delivery.

Recently, public policymakers have acknowledged the limitations of categorical approaches to addressing the needs of families. Policymakers now are supporting the development of programs that are more comprehensive and coordinated at the federal,

state, and local levels. One result of the evolution of integrated systems has been the development of public-private partnerships at the community level in such fields as health, education, mental health, social services, and early intervention.

As the locus of government responsibility continues to shift from the federal level to the state and local levels, it is imperative that communities continue their proactive role in planning, implementing, and sustaining integrated health, education, and social service systems that benefit the entire community. The National Conference on Community Systems-Building and Services Integration was a federal effort to nurture this process by fostering networking among people involved in cross-disciplinary systems-building and services integration activities throughout the country.

Purpose and Objectives

The purpose of the conference was to bring together people who are working to develop integrated systems of health, education, early intervention, mental health, and social services in various communities. The conference

provided a forum for participants to collaborate, plan strategically, share lessons learned, and establish mechanisms to facilitate ongoing communication and networking. Conference participants represented programs supported by both the private and public sectors, including federal, state, and local governments.

The conference objectives were to

- encourage the efforts of communities that are already engaged in local systems-building and services integration,
- facilitate ongoing networking and collaboration among communities and across disciplines,
- provide information about training, technical assistance, and funding resources that may be used to support community systems-building and services integration, and
- encourage other governmental, public, and private partners with similar goals to expand their support for community infrastructure-building and services integration.

The following definition of “system” provided a framework for the conference:

A system can be defined as a set of parts coordinated to accomplish a set of goals. In essence, a system is a set or group of interconnected, interdependent components that form a complex whole. Systems involve three essential elements: (1) purpose or goals, (2) components—structures and processes, and (3) components that must communicate to be coordinated. The central thread of any system is information and the flow of information between various links of the communication network that supports the operation of the system. (Grason HA, Guyer B, eds. 1995. *Assessing and Developing Primary Care for Children: Reforms in Health Systems*. Arlington, VA: National Center for Education in Maternal and Child Health.)

Underlying systems-building and services integration efforts are several principles:

Each local community, including informal leaders and families that need and use services, should identify its own needs and assets and have direct access to technical assistance that empowers the community to develop its own capacities.

- Individuals who work on organizational development and systems reform at all levels should build a common vision for systems reform.
- Technical assistance should be tailored to the collaboratively defined needs of local agencies, organizations, and institutions.
- Technical assistance among peers should be used whenever possible.
- Technical assistance must involve more than training individuals, families, providers, and other stakeholders to think and behave differently. It should also facilitate organizational change across the public and private sectors and support new ways of thinking and behaving.



-
- Technical assistance should flow horizontally among all participants in systems reform, as opposed to being a hierarchical movement. Everyone involved in systems reform has areas of expertise to share as well as technical assistance needs that must be addressed.
 - Family and professional partnerships at all levels of advocacy, policy formation, service delivery, and evaluation should be included in systems development activities. This approach will ensure that the systems developed and the services provided are effective and responsive to families and providers alike.

Agenda

The conference consisted of plenary sessions, networking sessions, and workshops.

Opening Plenary Session

Phyllis E. Stubbs-Wynn, M.D., M.P.H., Chief, Infant and Child Health Branch, Maternal and Child Health Bureau, HRSA, welcomed the conference participants. She described the conference as an effort to bring together communities that are actively working to end the fragmentation resulting from many years of categorical programs with diverse and unmeasurable funding streams. She praised the commitment of public and private health services organizations across the country to developing integrated service systems.

Dr. Stubbs-Wynn highlighted the collaboration of all four HRSA bureaus in planning the conference. She recognized the steering committee, which included members from the four bureaus as well as their public and private partners. She also recognized representatives of the cosponsoring organizations and the conference coordinator, the National Center for Education in Maternal and Child Health.

The time has come to stop developing programs separated by funding streams, Dr.

Stubbs-Wynn said. She emphasized the opportunity that the conference offered for networking among communities that are striving to develop integrated service systems, with support from federal and state agencies, foundations, and private-sector organizations.

Although conference participants might differ in their funding, focus, and objectives, Dr. Stubbs-Wynn said, they share the need to network across programs, funding streams, and communities to use limited resources more effectively and to strengthen efforts to build strong, community-based integrated service systems.

Audrey Nora, M.D., M.P.H., Assistant Surgeon General and Associate Administrator, HRSA, welcomed conference participants and noted two special aspects of this conference. First, all four bureaus of HRSA (the Maternal and Child Health Bureau, the Bureau of Primary Health Care, the HIV/AIDS Bureau, and the Bureau of Health Professions) worked together to organize it. Second, 21 private-sector organizations from across the country cosponsored the effort to showcase communities that are planning, implementing, and sustaining integrated service systems.

The aim of the conference was to lay the groundwork for continued network-building in the future, Dr. Nora said. Close cooperation among federal and state government agencies, community and nonprofit organizations, and the business community is essential to improve the health of America's children, she said.

Historically, Dr. Nora said, communities have developed strategies to address their individual needs. That approach has led to a system of weakly connected services that duplicate one another. Today, public policy-makers support the development of programs that are more closely coordinated at the federal, state, and local levels.

Dr. Nora discussed the four components of the federal government's Children's Health Initiative, for which HRSA is a lead agency,

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along with the Health Care Financing Administration:

- expansion of health insurance coverage for children
- outreach to Medicaid-eligible children
- identification of a health home for all children
- focus on communities as providers of population-based public health initiatives such as immunization and injury-prevention programs

Dr. Nora also noted that HRSA manages several programs that promote the growth and integration of health care delivery systems at the community level, including the following:

- Models That Work
- Community Integrated Service Systems
- Health Systems Development in Child Care
- Ryan White, Titles I, II, III, and IV
- State Systems Development Initiative
- Healthy Start, Healthy Tomorrows
- Integrated Service Network
- State Primary Care Associations

Dr. Nora emphasized the need for communities to maintain their proactive roles in planning and implementing systems of integrated health, education, and services that benefit the entire community. She said that HRSA regarded this conference as a starting point for the expansion of systems-building and services integration efforts across the country.

John P. Kretzmann, Ph.D., Co-Director, Asset-Based Community Development Institute, Northwestern University, was the opening keynote speaker. Dr. Kretzmann, who has worked for many years on issues related to the fostering of healthy communities, said that perceptions of communities are frequently shaped by a systemic approach that has defined them in terms of their needs and deficiencies.

Dr. Kretzmann urged the adoption of a new paradigm focused instead on developing

the strengths and capabilities that exist within communities. Central to this new paradigm is the use of capacity inventories rather than needs assessments. Dr. Kretzmann shared several anecdotes to illustrate his belief that the power and capacity for change reside within communities and that the success of community partnerships is bringing about modifications in the approach that governmental and nongovernmental agencies and organizations take to community development initiatives.

Dr. Kretzmann's address was followed by a reaction panel and a discussion session in which conference participants spoke of the challenges involved in implementing such a paradigm shift and described system-building efforts in their communities that echoed the themes Dr. Kretzmann had identified.

Networking Session I: Implementation of the Children's Health Insurance Program

Facilitators of the conference networking sessions were Martin J. Blank, Director of Community Collaboration, Institute for Educational Leadership, and Mary Skelton Roberts, Senior Associate, Program for Community Problem Solving.

Participants met in small regional groups to identify and discuss systems issues that are important to the successful implementation of the new federal Children's Health Insurance Program. By focusing on this initiative, the groups were able to identify many of the principles critical to the success of any systems-building effort. These principles included

- partnering with families in planning, implementation, and oversight;
- remaining flexible so as to respond to new issues and a changing environment;
- focusing on reducing complexity in the development and implementation of initiatives and implementation strategies;
- stressing community-based solutions;
- recognizing the importance and the dimensions of collaboration; and
- establishing accountability mechanisms.

Concurrent Sessions I, II, III: Showcase of Innovative Programs and Technical Assistance Workshops

During the conference, representatives from a variety of well-developed models of community systems-building and services integration (programs supported by HRSA or conference cosponsors) conducted workshops to share their implementation and sustainability strategies and to engage attendees in discussion of these strategies and others that have been used, successfully or unsuccessfully, in their communities. In addition, several organizations facilitated technical assistance workshops aimed at enhancing community workers' skills in critical areas of systems-building. Summaries of the workshop presentations appear in Part II of the proceedings.

Luncheon Remarks

C. Earl Fox, M.D., M.P.H., Acting Administrator, HRSA, stated that community systems-building and services integration are key issues for HRSA as it endeavors to increase access to health care for the underserved in communities around the country. HRSA believes that communities know their own needs best; the agency's challenge is to integrate services so that people can readily access them. HRSA has worked to reengineer its processes, and it wants feedback from the communities regarding these efforts, Dr. Fox said.

Dr. Fox noted that, as a result of legislation recently passed by Congress (Title XXI), the Department of Health and Human Services has embarked on a \$24 billion initiative to expand health insurance coverage for children. In fiscal year 1998, \$4 billion would be available to aid the many children who are currently in "medical limbo," often because their parents earn too much to qualify for Medicaid but not enough to purchase private insurance.

HRSA is networking with other agencies and public and professional organizations to link expanded insurance with access to health care for children. Other components of this effort include

- outreach to help communities find eligible children
- the designation of a "medical home" for every child to ensure comprehensive, coordinated care
- attention to those population-based issues for children that might go unattended if only the insurance component is addressed (for example, the special needs of children in foster care)

To identify best practices, Dr. Fox requested conference participants' help in documenting their own efforts. HRSA needs first to determine and then to implement the best strategies to leverage resources to build even better integrated systems of care in the United States, he said. Strategies need to be backed by data that demonstrate not only what is being done but also what works (evidence-based care).

More effective partnerships need to be established among federal, state, and local governments and the private sector, Dr. Fox said. Funding streams must become more easily blended, nationwide infra-structure-building must be improved, and children must be able to grow up healthy in the comfort and stability of a healthy home.

Dr. Fox told conference participants that they need to "strike while the iron is hot" to reduce fragmentation and improve services. "Right now, with opportunities like the children's insurance initiative, we think the iron is not only hot, it's blazing."

HRSA needs to draw on the best thinking of every conference participant to determine the best resources, training, and technical assistance that are needed to make progress in the development and implementation of integrated service systems, he said. In addition, conference participants need to capture the



attention of other organizations involved in providing social services for children and to make those groups their partners in the efforts being addressed at the conference.

Dr. Fox stressed that HRSA wants to help communities in their grassroots efforts. He challenged conference participants to set HRSA's agenda and to "set the bar high." He asked attendees to create action plans to improve services integration and avoid duplication. Networking and collaboration will help communities to sustain the momentum that has been developed, he said.

Luncheon Speaker

The Honorable Donald M. Fraser, former mayor of Minneapolis, Minnesota, was the luncheon keynote speaker. Mr. Fraser recounted how his views on the city government's responsibilities for children were transformed during his 15 years as mayor. Initially an advocate of targeted interventions for those at risk, he came to believe in the primary importance of strengthening the social infrastructure of neighborhoods and of creating social capital that would help all children. He urged conference participants to use their influence to create positive opportunities for the healthy development of all children.

Networking Session II: "What Have We Learned . . ."

Conference participants met again in small regional groups to identify and discuss lessons they have learned while working to build systems in their communities. Lessons identified included the following:

- *Community involvement is critical and complex.* Participants stressed the importance of inclusiveness, open communication, community ownership, leadership development, and flexibility.
- *Work on sustainability is required from the beginning.* Participants emphasized the importance of linking or relating new initiatives to current ones and the usefulness of continually creating new relationships that often grow into ongoing support.
- *Data are critical to the success of initiatives.* Participants noted that data are essential for monitoring and accountability and are also important in identifying gaps in communities' systems of services.
- *Technical assistance is important and must be planned in partnership with the community.* Participants stressed the importance of flexibility and the need for those who provide technical assistance to listen to

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and respect the views of community residents.

- *A positive working relationship with funders is critical to projects' success.* Funders and grantees must understand each other's needs. Among the needs of grantees that were identified by conference participants were funding flexibility and longer-term investments by funders.
- *States must model collaboration.* Successful community-level collaboration is strengthened when collaboration also occurs at the state and federal levels. Fragmented, categorical community-level initiatives are often the result of the categorical nature of state and federal funding and program requirements.

Networking Session III: "If I Could Have . . ."

In the final networking session, participants were asked to identify a "wish list" of items that could significantly strengthen their ability to foster systems-building in their communities. Five major areas were identified.

Communications

- Availability of technology that is usable and useful
- Creation of national Web sites with up-to-date information and follow-up contacts
- Presence of in-state cross-program Web sites

Networking

- Conference calls to facilitate networking across related programs
- In-state or regional conferences to exchange information and increase the visibility of systems-building efforts
- A national conference every other year

Skills-building technical assistance

- Use of performance measures
- Resource development
- Advice on how to work with state officials

- Social marketing
- Services integration strategies
- Managed care for local providers and performers
- Leadership development for consumers and other systems partners

Program support

- Funders' requirement of grantees to participate in collaboration efforts
- Funders' financial support of evaluation efforts
- Funders' encouragement of city-county collaboration
- Availability of block grants to community coalitions
- Built-in planning and evaluation time in project time lines

Federal integration

- Policies of individual federal agencies to promote interagency collaboration
- Policies and program strategies to be formulated by teams with federal, state, and local community members

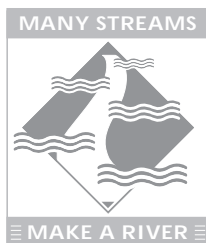
Closing Plenary Session

In the closing plenary session, reports from the networking sessions were shared with all conference participants. The closing keynote speaker was the Honorable Sharifa Wilson, vice mayor of East Palo Alto, CA. Ms. Wilson shared an inspiring story that described the power of community collaboration in bringing new life to her city. She identified several factors that made change possible: recognition that change was needed, willingness to be open, shared vision, ability of each group to identify an interest in the process, clearly articulated outcomes, and (last but not least) willingness to build relationships with members of the community.

Next Steps

A theme running through the entire conference was the importance of both horizontal and vertical collaboration at the community, state, and federal levels. Attendees involved in community systems-building recognized and valued the critical role that government agencies and private/voluntary organizations play in successful systems work in communities. They also articulated the areas in which they need guidance and support from those agencies and organizations. Therefore, the next logical step for the agencies and organizations that served as sponsors and cosponsors of the conference is to address the following questions:

- How can collaboration among government agencies and private/voluntary organizations be continued and strengthened so as to contribute to community systems-building efforts?
- Which of the “If I could have . . .” wish list items can these partners implement together?
- What collaborative strategies can these groups most effectively pursue? ▲



National Conference on Community
Systems-Building and Services Integration

Part II

Workshop Summaries

Concurrent Sessions I: Showcase of Innovative Programs

Hale Empowerment and Revitalization Organization

*The Honorable William (Sonny) Ryan
Richard Rhone, Ed.D.*

Community Profile

Hale County is a rural “black belt” county in west-central Alabama with a population of 15,000. Its major employers by sector are manufacturing (primarily food processing), government, farming, and retailing. The county’s per capita income is \$11,783—59 percent of the national average.

About 24 percent of county residents receive food stamps. In 1990, 46 percent of the population did not have a high-school diploma; fewer than 10 percent had a college degree. More than 30 percent of children live in single-parent households and 46 percent live in poverty. About 18 percent of live births are to unmarried teenagers, which is above the state average of 12 percent. Rates of low birthweight and infant mortality are also above the state average.

Community Systems-Building Effort

Interest in applying for federal funding under the Empowerment Zone/Enterprise Community program led to the formation of the Hale Empowerment and Revitalization Organization (HERO) in 1994. Although HERO was not selected for empowerment zone funding, its effort was the catalyst for a community partnership-building process that led to the inception of a variety of grassroots-initiated programs focusing on economic, human, and infrastructure development and community revitalization.



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About 250 people representing community organizations, county government agencies, local employers, law enforcement and criminal justice agencies, the school system, and local churches participated in the HERO strategic planning process. The organization, which is headed by an all-volunteer interagency steering committee, serves as a focal point for identifying and sharing community resources and talents, and directing these toward improving the quality of life in Hale County.

Programs and services that have been developed to date through partnerships with state agencies, local employers, educational institutions, and civic organizations include the following:

- A community-based, nonprofit Family Resource Center was established with the aim of strengthening families by providing them with the skills and resources to help themselves. The center serves as a “one-stop-shopping” center for services such as job training, adult basic education, and family counseling.
- Bright Beginnings, an outreach program for first-time expectant teens and teen mothers, offers home visits, counseling, and encouragement to obtain prenatal care and to remain in school.
- A \$1.4 million project to revitalize the downtown area of Greensboro (the largest center in Hale County with a population of about 3,000) is now more than half completed.
- A partnership involving HERO, the Hale County Department of Human Resources, and a large local employer resulted in a successful program to reduce employee absenteeism through on-the-job training and education for new employees.
- A partnership with Auburn University involved architecture students in designing and building quality, low-cost homes for some of the 1,700 Hale County families living in substandard housing.
- An effort to identify individuals in the

community to whom others turn for help resulted in the formation of Natural Helpers, an all-volunteer group of trained community leaders.

Results of these initiatives so far include placement of more than 100 local residents in jobs, a 30 percent reduction in the number of welfare recipients, and a 20 percent reduction in the number of recipients of food stamps.

A commitment by a wide range of organizations and individuals to work together has led to the elimination of many turf wars that had previously been a barrier to change. Some segments of the community remain outside the systems-building process. The participation of both white and black people in HERO has met some resistance and one agency has refused to cooperate with HERO, regarding it as a competitor. Despite these difficulties, however, much has been achieved. An activist approach and a willingness to attempt things that have not been done before are key contributors to the progress that has been made to date.

National Native American AIDS Prevention Center

Paul Bouey, Ph.D., M.P.H.

Community Profile

The National Native American AIDS Prevention Center (NNAAPC) does not serve a geographically distinct community. Rather, it serves as many of the nation's more than 1,500 HIV-positive Native Americans as possible. The center's definition of Native Americans includes Alaska Natives and Native Hawaiians.

Because the number of HIV-positive Native Americans is small, funding for services to this population is scarce. The Indian Health Service (IHS) ended its pharmaceuticals support program for Native Americans with AIDS in 1994 and closed its national AIDS office in 1997. IHS now directs its resources to the treatment and prevention of diseases that

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affect large numbers of Native Americans, such as diabetes, substance abuse, and injuries, and those resources are largely directed to reservations.

Although 50 to 60 percent of Native Americans live in urban areas, only 2 percent of IHS funds are spent on urban services. As is the case with other demographic groups, the AIDS epidemic among Native Americans is based in cities. However, Native Americans who become infected with HIV in the city tend to move home when they get sick. A pueblo community of 50 Native Americans can be overwhelmed when just 1 or 2 of its residents develop AIDS.

The Centers for Disease Control and Prevention (CDC) predicts that the number of Native Americans with HIV infection or AIDS will continue to increase. However, improvements in therapy have resulted in a decline in the death rate from AIDS in this population.

Community Systems-Building Effort

In 1991, the NNAAPC undertook to develop a model for overseeing and coordinating the care of HIV-positive Native Americans at a site in Oklahoma. The Health Resources and Services Administration (HRSA) then gave NNAAPC a grant to duplicate the model at 11 sites. NNAAPC is now in the first year of a follow-up 5-year grant from HRSA and is providing case management at 8 rather than 11 sites.

NNAAPC runs its headquarters and one case-management site in Oakland, CA. Subcontractors run the seven other case-management sites in Phoenix; Oahu and Maui in Hawaii; New York City; Oklahoma City/Tulsa; Minneapolis; Kansas City, KS; and in the Navajo Nation.

The center has developed a flexible model of case management. Both Native Americans and non-Native Americans serve as case managers; being Native American is not considered a guarantee of cultural sensitivity. Because of the cultural importance of trust for Native Americans, case managers invest a lot of time in establishing relationships with their clients.

At intake, the case manager gathers information about the individual's HIV status, physical and mental health, insurance status, demographics, and information about the services being sought. The case manager then develops a care plan and refers the individual to the appropriate agencies. The case manager monitors the individual closely thereafter, making contact either by phone or in person three times a month. The case manager also acts as the client's advocate, interceding and smoothing the way when problems arise.

NNAAPC headquarters staff members collect data on the population they serve and conduct annual satisfaction surveys. Headquarters also provides staff at all case-management sites with training in writing grants and handling budgets. Information about activities at different sites is shared through meetings and publications distributed from headquarters, so that staff members at case-management sites can learn from each other's mistakes and successes.

Some community health care providers feel that they do not know enough about AIDS to treat HIV-positive Native Americans. NNAAPC wants to identify interested providers and send them to an AIDS education and training center. The center also wants to collect data on HIV-positive Native Americans from cities outside its network, such as San Francisco, which has the largest number of HIV-positive Native Americans in the United States.

NNAAPC plans to change its model to be more sensitive to the needs of HIV-positive Native American children. In addition, it hopes to develop a uniform instrument for data collection.

Hillsborough County Health Care Plan

Cretta Johnson

Community Profile

Hillsborough County, located on the west coast of Florida, includes Tampa and two smaller municipalities. An estimated 40,000 of

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the county's 1 million residents have no health insurance and either have incomes below the federal poverty level or have nonreimbursed medical expenses that reduce their income to that level.

Indigent citizens, lacking access to primary care, were frequent users of Tampa General Hospital's emergency department. Before implementation of the county's health care plan, the average hospital stay for this population was 10.6 days, compared with the state's average inpatient stay of 6 days. Health care for the uninsured and indigent was costing the county \$600 per person per month. In general, the county's health care services for the indigent were fragmented and poorly coordinated.

Community Systems-Building Effort

The Hillsborough County Department of Health and Social Services became interested in containing the cost of providing medical care to the indigent when it realized that it was paying Tampa General Hospital \$22 million annually to care for them.

The Board of County Commissioners convened a 15-member health care advisory board—whose membership included physicians, legislators, financial planners, insurance experts, and community representatives, but no government representatives—to propose ways to make the delivery of health care to the indigent more cost effective. The details of the plan were finalized by subsequent task forces made up of physicians, citizens, members of the chamber of commerce, and the uninsured themselves.

The result, implemented in 1992, is an award-winning public-private partnership comprising physicians, hospitals, 12 primary care clinics, and 60 county agencies, overseen by the county health department. The target population is the uninsured and those persons with incomes of up to 100 percent of the federal poverty level, including the working poor and those who have "spent down" to poverty level paying medical bills.

To date, 28,000 people (70 percent of the target population) have been enrolled in the health care plan. Fourteen percent of the enrollees are children between the ages of 14 and 18, who are too old to qualify for the state's Medicaid program.

Every member of the health care plan has a "medical home" with a primary care physician in the community. That physician, acting as a gatekeeper, makes referrals as needed to medical specialists and for other services. The plan emphasizes prevention, and the savings have been dramatic. It now costs the county \$200 rather than \$600 per person per month to provide health care to the indigent population. The average hospital stay for a member of this population at Tampa General is now 5.9 days.

The plan, which was financed by a half-cent sales tax, divides the county into four zones, each with its own network of physicians, clinics, and hospitals. The county pays each network a capped fee to care for its eligible indigent population. Physicians then negotiate their fees within that capped amount, in a marriage of managed and fee-for-service care.

Utilization review nurses are on site at participating hospitals to conduct concurrent review and preapproval of expensive procedures such as magnetic resonance imaging. A formulary was developed by two pharmacists, who have the sole authority to grant exceptions.

Although participating providers bear 100 percent of the liability risk, there have been no malpractice suits since the plan's inception in 1992. Administrative costs are 4 percent annually, much lower than any other health maintenance organization.

The health plan has a fleet of 40 vans to transport people to their physician appointments. Social workers assess special needs that interfere with individuals' ability to use cost-effective health care services. Installing a telephone in one person's apartment made home intravenous therapy possible and eliminated the need for 23 days of hospitalization.

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An estimated 25 percent of the target population has some psychopathology. Of those people, 60 percent could be treated by a primary care physician. The next step will be to train primary care physicians in the recognition and management of mental illnesses that fall within their area of competence, thereby further reducing health care costs.

The program has been so successful at decreasing medical costs that it has produced a reserve of \$140 million. As a result, political leaders reduced the sales tax to \$0.25.

Local INvestment Commission

Tim Decker

Community Profile

The community served by the Local INvestment Commission (LINC) includes some of the poorest neighborhoods of Kansas City, MO, as well as some of its poorer suburbs in adjacent Jackson County. The communities are marked by schools where children do not succeed, families with absent fathers, unsafe neighborhoods, neighbors unacquainted with each other, few sources of primary or preventive health care, and neglected public parks.

Community Systems-Building Effort

LINC, the longest-standing community governing body in Missouri, was started in 1992 by a Kansas City businessman. Through his participation in a business roundtable that advised the state Department of Social Services on everything from child support enforcement to child protective services, the businessman was aware of the problems facing children and families and decided to do something to improve the plight of children in Kansas City. His initial effort to legislate improvements failed miserably. Then he adopted a grassroots approach to improving the lives of children by improving the lives of families. LINC's credo is to involve families in decisions about what improvements are needed and how they should be made.

LINC is governed by 36 commissioners who are appointed to 3-year terms by the director of the state Department of Social Services, who also deputizes them to act as the department's agents. The commissioners, all lay persons, include community activists, welfare recipients, and neighborhood residents. They are advised by a professional cabinet of 22 members representing government agencies. Members of the cabinet have no vote.

LINC has projects underway at 16 sites in Kansas City and Jackson County. Another 10 projects are planned to start in 1998. Among the successful projects to date are the following:

An effort to save the area's only two school-based health clinics from closing. As a result of LINC's community-based effort, the two clinics remained open and eight more clinics opened at other local schools.

An expansion of school-linked services, funded by a \$24 million authorization that was made possible by an unusual collaboration among four state departments: health, mental health, education, and social services.

An approach to welfare reform that predates the federal mandate. Under dual waivers granted by the U.S. Department of Health and Human Services and the U.S. Department of Agriculture, money from the federal Aid to Families with Dependent Children (AFDC) and food-stamp programs was converted into a wage supplement that was paid to a welfare recipient in a new job. Such supplements make it possible for small employers to create jobs and to pay participants in welfare-to-work programs at least \$6 per hour in addition to fringe benefits. Through this program, LINC has moved 1,200 people from welfare to work; those placed in jobs have kept them for at least 3 months.

Educare, which provides training in child development, safety, and health issues for people who offer child care in their homes. The home child care centers might not be licensed and the people who operate them

might not be declaring their income, but at least the children are receiving better care.

LINC's initial funding came from the Missouri Department of Social Services, which funded administrative and support staff. Funding continues to come from various state programs, depending on the focus of the project: child health, education, safety, adult employment, and so on. Foundations have provided funds for several new programs; the state assumes the funding once the program proves viable. Bipartisan support for LINC ensures that state funding of the program will continue.

Community members had to be trained in consensus development, organization, assessment of leadership style, and other skills that taught them how to develop their own resources.

Decisions made at the neighborhood level are not necessarily good decisions. Participants must learn how to operate credibly—for example, it is not credible to give a contract to a friend. Issues of race, class, and geography come up frequently.

Rural Partnership for Children

Kim Engel, M.B.A.

Lori Rosane

Community Profile

The Rural Partnership for Children was established to serve a rural area in northwest Nebraska. (Ninety of 93 counties in Nebraska are considered rural.) The target population is designated “frontier,” averaging fewer than six persons per square mile. Many residents must drive 2 or more hours to reach a doctor, and mental-health counseling and related services are lacking. Twenty percent of the children under 18 live in households with incomes below the federal poverty level. Of 205 pediatricians in Nebraska, only 31 are outside Omaha and Lincoln.

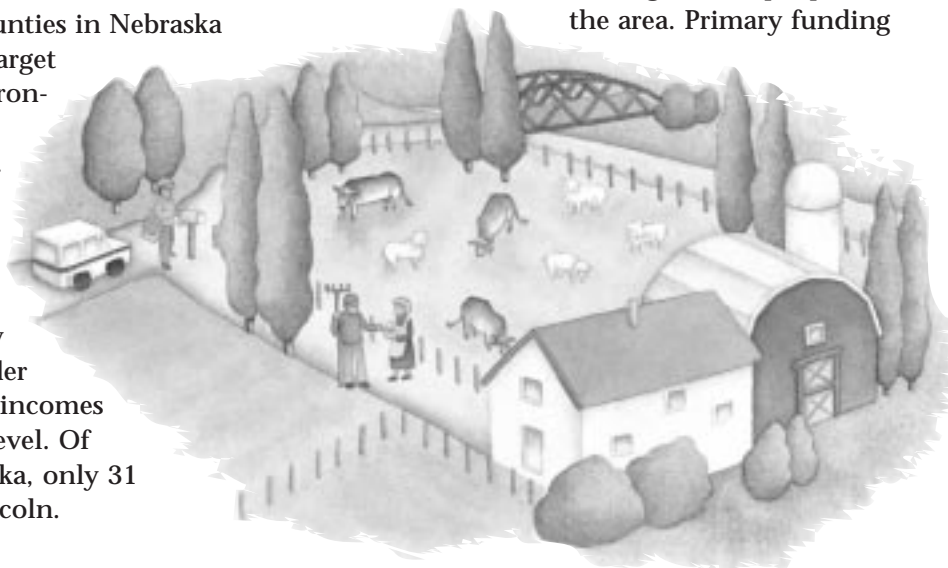
Community Systems-Building Effort

The Rural Partnership for Children was developed originally to serve children with special health needs in a four-county area. The goal was to improve the quality of health care services through increased access to and coordination of services. The 5-year demonstration project was initially funded (October 1990 to September 1995) by the Healthy Tomorrows Project.

The partnership provides a range of services, from preventive to long-term care. The program is customer focused, family centered, and community based. It uses community care networks (physicians, nurses, schools, mental health facilities, and others) to coordinate services for families, with local access provided through rural hospitals. Local, cross-trained nurse/case managers handle registration, scheduling, referrals, and other arrangements for a variety of family services. Referrals for behavior-related problems were much higher than anticipated.

With the participation of pediatricians from regional health centers, monthly pediatric-consultation service clinics rotate among the four counties. The nurse/case managers assemble comprehensive case information for the consulting physicians before their 1-day visits.

The partnership's scope has expanded to include coverage for all people in the area. Primary funding



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since October 1995 has come from Western Community Health Resources (WCHR), a collaboration of three local rural hospitals.

Using the case-manager model, WCHR focuses on providing education, services, care, and referrals to optimize mental, physical, and social well-being for families. Programs include the Special Supplemental Nutrition Program for Women, Infants and Children (WIC), immunizations, family reproductive health, a commodity supplemental food program, and a maternal and child health program.

By working as partners, the WCHR hospitals have achieved much stronger cooperation. Their relations with physicians, who at first did not universally welcome the program, and with the community as a whole have improved as the value of the partnership has become evident.

Each of the four counties has developed a Family Preservation Group, with representatives drawn from education, health, law enforcement, domestic violence, elders, youth, special education, families, community action, and related focus areas. The Family Preservation Groups also include representatives from city and county government, county extensions, chambers of commerce, media, Habitat for Humanity, Head Start, and the Red Cross. In the planning process, the groups considered their goals for target families in 2000, as well as current risks, needs, and capabilities. The groups informally developed the Family Nurturing Coalition to facilitate cooperation among the four counties.

By responding to different communities' varying delivery needs (such as on-site services, after-hours scheduling, and transportation to distant services), the partnership has brought health care to people who otherwise would not drive long distances for the help they need. Community-based services have resulted in better education and improved community relations.

The Nebraska Panhandle Partnership, covering an 11-county area, is now developing a

similar model. The planners are finding the task much more difficult because more planners, more government bureaucracy, and greater distances are involved than in the Rural Partnership for Children. The projected restructuring of services has led to anxiety about potential personal impacts on funding, jobs, and decision making. Logistically, traveling between the area's most distant points requires a 5-hour drive, and attending a planning meeting in a central location can involve a drive of more than 2 hours.

For the Nebraska Panhandle Partnership and WCHR, however, the program has succeeded because the planners built on their existing capabilities to meet a variety of needs. The keys to their success and to the program's sustainability have been planning, communication, and teamwork.

Growing Into Life Task Force

Karen Papouchado

Barbara Strack

Community Profile

Aiken, SC, is a city of 24,000 in a rural county. It has assets of "old money" and enjoyed a high education and income level during the Cold War as a result of the construction and operation of a plutonium plant. As the plant's importance declined, social problems followed. The infant mortality rate in 1989 was 12.1 per 1,000, one of the highest in the nation. Child abuse also was a concern; 13 children suffered violent deaths while under social service care.

Community Systems-Building Effort

Growing Into Life began in 1989 as an effort to address Aiken's alarming infant mortality problem. The task force, which now has 120 members, is a public-private partnership that involves physicians, community volunteers, students, and politicians. Racially, ethnically, and politically diverse, the group's membership crosses all income levels and regards its diversity as central to its success.

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The task force collected baseline data, talked with women to identify barriers to accessing prenatal care, and resolved turf problems between the county health department and the for-profit hospital. One of its most innovative initiatives was to cross-train police officers as frontline health outreach workers.

An Infant Mortality Task Force was established with a federal grant. The group used three key evaluation tools.

- A Fetal and Infant Mortality Review Board reviewed in depth each infant death in the county. The board's membership included obstetricians, pediatricians, nurses, the coroner, social workers, and a sheriff's deputy.
- Over a 1-year period, community volunteers surveyed 447 women in the hospitals where they had just given birth. The survey collected medical and demographic data as well as information about mothers' attitudes toward their pregnancies.
- Sociology students from the University of South Carolina-Aiken posed as family-planning clients to evaluate, from the perspective of low-income patients, the prenatal care offered to Medicaid patients.

Several actions were taken in response to the data collected.

- Clinic and hospital nurses worked to establish the Pregnancy Care Line, a 24-hour hotline for Medicaid patients staffed by obstetric nurses from the for-profit hospital. The planning effort took 18 months to complete but saved a mother and her newborn within the first month of the hotline's operation.
- An 800 number was established for rural residents.
- An identification card was developed to contain the patient's medical record, reducing delays in treatment.

In 4 years, the program reduced infant mortality by 40 percent to 7.2 per 1,000. Its

goal now is to reduce the rate to 5 per 1,000 births.

The task force has two part-time employees and is funded by the South Carolina March of Dimes. In 1992, it expanded its focus to include domestic violence and child abuse. Other programs developed by the task force include the following:

- Bicycle-mounted community police teams advise women about the need for prenatal care. The officers also keep a friendly eye on new mothers and babies in their assigned neighborhoods.
- Volunteers visit each new mother and baby in the hospital. At times, the volunteers have learned of potential risks to patients (such as threatening situations in the home environment) that were not apparent to medical personnel.
- The program has established free public access to the Internet as a means of conveying current information to low-income patients. One Internet station is located in a Laundromat.
- The city of Aiken established a homeownership program to improve housing for low-income residents.
- The city's strategic planning process involved the input of 300 citizens who met over an 18-month period. Because so many of the participants were also involved with Growing Into Life, the issue of health became a central concern. Gradually, the city's strategic plan evolved into a Healthy Community Plan.

Growing Into Life has achieved award-winning successes in lowering Aiken's infant mortality rate and increasing patients' awareness of the importance of prenatal care. Key qualities required to reach the task force's goals have been adaptability, tenacity, and flexibility. To overcome political and other barriers, the task force attempts to go over, under, around, and through obstacles. As far as possible, it tries to use a side-by-side rather than a head-to-head approach.

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NOTE: The following workshop was repeated in Concurrent Session III.

Healthy Families Partnership

Deborah Russell

Teresa Woodard, R.N.

Joseph Zogby, M.S.W.

Community Profile

Hampton, VA, is a city of about 148,000 residents, of whom roughly 55 percent are white; the rest are African American except for a small number (1–2 percent) of people of other ethnic or national origins. There is a large military population, and the income level is fairly low.

Community Systems-Building Effort

The Healthy Families Partnership is the city of Hampton's response to rising demand for services at a time of dwindling budgets. In 1991, the helping agencies in the community were increasingly unable to deal adequately with the number, complexity, and severity of issues facing many families.

A group of department heads and directors from quasi-city agencies and nonprofit organizations had been meeting regularly to explore the problems they faced. Because most cases of child abuse and neglect occur during the first 5 years of life, before at-risk children come to the attention of school officials, the group decided to focus its limited resources on the prevention of these problems. Its goal was to ensure that every child born in Hampton is born healthy and undamaged and enters school healthy and ready to learn.

Every agency or business group that joined the steering committee was expected to provide resources. To build support for the program, the committee stressed the economic advantages of preventing problems rather than dealing with consequences. The steering committee progressed from conceptualization to implementation in only 11 months and launched the program in August 1992.

The partnership includes a Healthy Start Program, aimed at families identified by hospitals, doctors, and health maintenance organizations (HMOs) as overburdened and in need of family support. The program has four goals:

- assessment of strengths and needs, with referral for services as needed;
- enhancement of family function;
- promotion of children's growth and development; and
- promotion of positive parent/child relationships.

The program uses a multidisciplinary approach, with a registered nurse, a social worker, and five family support workers on each team. Parents receive help to expand their family support systems and develop problem-solving and advocacy skills, effective parenting techniques, and home management skills. The program has realized a reduced rate of high-risk pregnancy, a decreased delivery risk, an increased immunization rate, and a reduced rate of repeat teen pregnancy. Having observed the help others are receiving, parents are eager to join the program.

The Healthy Community program focuses on primary prevention activities. From the prenatal period to a child's fifth birthday, parents receive a series of newsletters that address topics such as nurturing self and child, age development, age-appropriate activities, developmental milestones, and safety issues and that also provide references to related library materials. A new series will cover issues for the period from kindergarten through high-school graduation. In addition, a bulletin geared to the child's age is published every other month. It contains current community information about, for example, family activities, immunization checks, and new vaccines.

Another program, Healthy Teen, aims to prevent teen pregnancies by making teens aware of the social, economic, legal, and personal consequences of premature parenthood.

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The program is school based; a community-based program serves teens who are not attending school. A Young Family Center has been established in every branch of the public library and a Parenting Resource Center is being established in two elementary schools.

The partnership offers 70 parenting programs that use 15 curricula. To encourage attendance, the programs provide transportation, if needed, as well as both child care and dinner. Local restaurants provide meals at no cost to the participants. Parenting programs during the prenatal period are conducted in partnership with a local hospital. Such programs are also provided for several local businesses during work hours. Another popular new effort is the Dynamic Dads Program, which uses male facilitators.

During the program's first 4 years, a Community Integrated Service Systems grant provided the primary funding. When the grant ended, the city took over the funding because the program's effectiveness and cost-effectiveness had been well documented.

The partnership has never had an executive director. Program directors report to the steering committee. The partnership provides services without charge to all families and has received tremendous respect and support from the community in return.

Concurrent Sessions II: Technical Assistance Workshops

Asset-Based Community Development Institute

Byron White

The Asset-Based Community Development Institute (ABCDI) is a consulting organization that helps communities throughout the country identify and mobilize their assets as the first step toward community development. Headquartered in Chicago, the institute draws on the talents of 20 to 25 experts (for exam-

ple, university professors, ministers, journalists, directors of nonprofit agencies) in the asset-based approach who work in a variety of fields and in different areas of the United States. ABCDI also produces materials such as workbooks and videos for communities to use in their capacity-building efforts.

ABCDI was established to counter the needs-based approach of most community development programs—an approach that focuses on a community's deficiencies. The asset-based approach, by contrast, focuses on the resources and talents within a community. The needs-based approach fosters dependence on an outside entity to identify problems and provide solutions, whereas the asset-based approach fosters independence and self-directed problem solving.

For example, when school testing revealed that all but one student at an elementary school had performed at a level below the national norm, civic groups from outside the neighborhood took the traditional needs-based approach and imposed an educational reform program on the school. An asset-based approach would have begun by enlisting the parent(s) of that one successful student to lead teachers and parents in a within-school reform effort.

ABCDI acts as a consultant in such situations, helping the community to apply the asset-based approach to its own circumstances. It avoids being an outside agent that instructs a community in how to solve a problem, but rather guides the community to find its own solutions from within.

The first step in most needs-based community development programs is to use a "needs assessment" tool to describe the community's problems. Thus, a detailed delineation of the community's deficiencies is the cornerstone of the program. A needs assessment does not serve the community because its people are already well aware of their problems. ABCDI advocates instead the use of such tools as the "asset map," which records the community's resources, individuals' talents, and local insti-

tutions and associations that may help in capacity-building.

Similarly, ABCDI recommends that communities create a “capacity inventory” to quantify the gifts that each resident can contribute to the neighborhood’s betterment and an “associational inventory” to list social groups in which interpersonal interaction and information sharing take place.

Groups may include informal mothers’ groups that meet while supervising children in a playground, jogging groups whose members run the same route at the same time, and formally organized groups such as church clubs or neighborhood block organizations. These associations furnish a means for assembling and coordinating the community’s talents and skills, as well as for focusing the energy needed to make changes.

The following examples illustrate how an asset-based approach helped with several community programs:

- One community identified its eight hospitals as an asset and enlisted them to address the problem of poor communication between doctors and patients. The community linked hospital interns with local high-school students in a program where students played the roles of patients, then videotaped and critiqued the interns’ performances as doctors. In this way, the doctors learned to be more culturally sensitive to the people they served and the profession of medicine was demystified for the students.
- Many communities that lack adequate child care for working mothers and adequate employment for older residents have solved both problems simultaneously by encouraging unemployed older adults to provide child care in their homes.
- A research center that needed help conducting a health survey in one underserved community enlisted several community members to develop a better survey tool and an approach that would put people at

ease so they would provide more information. These community members went on to find full-time work with the research center, where they were considered experts at obtaining essential medical information in difficult circumstances.

Parent Training Program: Selecting the Best Program and Staff Training for Your Community

Kerby Alvy, Ph.D.

Many fields not directly related to parenting support the effective parenting movement because it is essential to accomplishing their goals. The movement is supported by those people involved in

- crime prevention—because most violent criminals have a history of abuse by their parents,
- mental health—because many mental disorders are caused or exacerbated by bad parenting,
- pediatrics—because proper nutrition and injury prevention, which depend on proper parenting, are key to child health, and
- education—because good parenting is critical to success and achievement in school.

The effective parenting movement, which began in the 1960s and 1970s, initially targeted average parents who had ordinary difficulties in caring for children. Gradually, proponents realized that these programs were not helpful to families who did not fit the “average” mold, such as non-white and non-middle-class families and families with children with special needs. New programs were developed that were tailored to meet the specific needs of these and other groups and to address each developmental stage of childhood.

There are now three types of parenting programs:

- *Parent support programs* are run by a facilitator who helps groups of parents with prob-



language and geared to the parents' reading level; in the case of illiterate parents, such materials should be pictorial.

Because different cultural groups have different expectations, particularly regarding gender role distinctions, programs must be sensitive to cultural issues. Members of ethnic groups with a history of discrimination need programs that help them teach their children to "reject rejection" and emphasize pride in their heritage. Parents with special concerns (for example, teenage parents, parents of disabled children, abusive parents, and substance-abusing parents) need

programs that address their specific needs.

- lems that the parents bring up for discussion.
- *Parent education programs* are run by instructors who have a specific curriculum to impart to parents regarding such issues as child development, accident prevention, discipline, and communication.
 - *Parent training programs* are run by instructors who teach specific, hands-on skills using a structured curriculum that is time-limited and must be presented in a particular way.

The United States has at least 50 to 60 excellent parent skill-building programs; the number alone can make it difficult for community groups to choose the one that best suits its needs. To select a suitable parent training program, a community should conduct the following assessments:

- *Assess the parents who will be trained.* Highly educated parents respond better to training techniques that are intellectually challenging and verbal, whereas parents who have less education respond better to action-oriented, less verbal techniques. Written materials should be in the parents' native

- *Assess the children who will be affected.* Some programs are geared to certain age groups, such as babies and toddlers, and would not be helpful for others, such as adolescents. Children with special concerns, such as behavioral disorders, physical disabilities, or learning problems, need programs that address their specific needs.
- *Assess the available programs.* Content, the most important variable in parent training programs, should be chosen to match the parents' needs. For example, if preventing physical abuse is a concern, the program must cover corporal punishment. If the parents live in a neighborhood where substance abuse is pervasive, the program must address risk factors for substance abuse.

The length of training also is important. Longer programs allow for getting across more information and reinforcing skills, but they are more difficult for parents to attend. The two best training methods are the interactive approach that models appropriate behavior (for example, by engaging parents in role-

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playing) and video training. Both approaches make it easier for parents to retain the information.

The program presenter must have an appropriate level of education and experience with both group dynamics and child development. The availability of technical assistance can be important if the community needs technical help to implement the program. Finally, the program must teach information and techniques that have been shown through research to produce the desired outcomes.

Dr. Alvy's Center for the Improvement of Child Caring (CICC), based in Studio City, CA, sponsors parenting seminars and workshops throughout the United States. CICC has trained more than 5,000 instructors in 44 states; these instructors have, in turn, provided programs for hundreds of thousands of parents. CICC also publishes a catalog of dozens of parenting programs, as well as parenting books, videos, and other materials for parents, instructors, and communities.

Coalition for Healthier Cities and Communities

William Powanda

The Coalition for Healthier Cities and Communities is a partnership of public- and private-sector entities that focus attention and resources on improving health and quality of life through community development. The coalition's goal is to assist in starting up healthy community initiatives and in maintaining those that are already under way.

Communities identify their own health issues and the coalition helps them to allocate new resources or reallocate existing resources to address those issues. Thus, the communities design and manage their own solutions to a wide variety of problems that affect health or quality of life.

The coalition first met in 1994 in response to the growing "healthy community" movement; it currently includes approximately 120 participating organizations and individuals.

Last year the coalition was recognized by General Colin Powell's organization, America's Promise, as a major partner in the effort to improve the lives of youths in 2,000 American "communities of promise." The coalition is working with America's Promise to

- identify and fund initiatives that encourage ongoing relationships between youths and caring adult mentors, tutors, or coaches;
- provide access to safe recreational areas and structured activities;
- provide a healthy start in life;
- ensure that youths acquire a marketable skill through effective education; and
- furnish opportunities for youths to perform community service.

One example of a coalition-supported healthy community initiative is Healthy Valley 2000, a project formally launched in 1994 to assist six south-central Connecticut towns in coping with dramatically fluctuating demographics and the accompanying shifts in health and human services needs among their residents. Healthy Valley 2000 currently coordinates 37 projects in arts and recreation, economic development, community involvement, education, and health. Some examples include the following:

- A project known as "electronic valley," in which volunteers have completely replaced outmoded information and communications systems throughout the area. The work, which included placing personal computers in several community centers to enhance public access to information, was valued at \$100,000 but was accomplished at no cost.
- A playground safety program that succeeded in closing down the most unsafe play areas and making thousands of dollars worth of repairs to other playgrounds at minimal cost.
- An award-winning hospital program to ensure the health and well-being of infants and mothers who must be discharged within 24 hours of childbirth because of health

insurance requirements. Ninety percent of these families return to the hospital after 72 hours for a free assessment that detects and offers immediate treatment for incipient problems.

- A mammography screening program to improve the 20 percent rate of use among Medicare-eligible women living in the valley.

The coalition specializes in linking communities that are just beginning to undertake such initiatives with the resources they need to succeed, including relevant case studies of similar initiatives, educational and training materials, and opportunities to build alliances with other communities as well as with local, state, and national policy-making agencies.

The DELTA Project

Anne Harrison-Clark
Hank Swan

The DELTA Project assists communities in the creation and implementation of long-range plans for social and economic development, primarily by sharing the experiences of other communities that have successfully addressed the same issues. The DELTA Project can only assist communities in which the public, private, and volunteer/grassroots sectors are cooperating to make improvements.

With other community development assistance programs, particularly those operated by government agencies and charitable foundations, support usually is short-lived, the approach is piecemeal, the agenda is set by the group that provides the assistance, and the program's success is judged by the providers themselves on the basis of how well they adhered to their strategic plan rather than on real-world results. In contrast, with the DELTA Project

- support is long-term (10–20 years);
- the approach is comprehensive rather than piecemeal;

- the community must initiate, control, and coordinate its community development activities and thereby set its own agenda rather than rely on an outside agency's agenda; and
- success is measured throughout the process by objective benchmarks determined by the community, not by an outside entity.

The DELTA Project does not advertise its services and offers assistance only to communities that seek its help. Its service has two components: the DELTA Process and the Community Works.

The first step in the DELTA Process is to help the community develop a shared understanding of both its most pressing social problems and its priorities in solving those problems. Then the DELTA Project helps the community develop and implement successful long-term strategies, programs, and partnerships to solve its problems. This usually involves a 10- to 20-year commitment to a dynamic process during which initiatives, partnerships, and strategies change over time.

Community Works is a source of information, expertise, and technical assistance that communities can draw on when they undertake development programs. It links them with other communities throughout the country that have already addressed similar problems and provides access to the people who conceived and implemented those programs.

Within the next 18 months, Community Works will include a collection of Help Desks in seven specific problem areas, staffed by experts in those areas. The problem areas are community development, economic development and job opportunity, education and job readiness, health and human services, housing and neighborhood development, public safety, and natural resources and local environmental quality.

The DELTA Project is allied with the National Association for the Southern Poor, the National Hispanic Education and

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Communications Projects/Education Leadership Council, and the Center to Prevent Handgun Violence.

Harrison Institute for Public Law

John Pomeranz

The Harrison Institute for Public Law, part of Georgetown University Law Center, works with community groups and elected officials on health care and community development issues. One of the institute's main areas of focus is helping to ensure that community groups are not left "out of the loop" when managed care overtakes a medical facility or a health care plan in a locality.

In such health care conversions, a medical facility—typically a nonprofit or public or government-run hospital—transfers most or all of its assets to a for-profit institution in an action that may be termed a sale, a merger, a joint venture, or a lease. To the layman, it may not appear that the hospital property has been officially transferred, but in reality the for-profit institution takes over running the hospital. Often, this entails major changes in the types of services the hospital provides, the fees it charges, and the patients it accepts; where the public hospital answered to its patients, the for-profit hospital answers to its shareholders.

Even though the hospital has been not-for-profit, it has accrued assets over the years. The assets should be transferred back to the community in a way that serves the same charitable purpose that the nonprofit institution served. To do this, when hospitals convert from nonprofit to for-profit institutions, they often set up a fund equal to the amount of their assets and a charitable foundation to oversee the fund.

However, when such conversions occur, most for-profit organizations do their best to minimize their assets. Because many communities and even many state legislatures do not understand this process, they often are not on guard to protect the community's interests

when such a conversion takes place. Only active community involvement can ensure that communities are not shortchanged and that they benefit from these conversions.

For example, when Blue Cross of California converted from nonprofit to for-profit status, it tried to keep any assets from being set aside in a charitable fund. As public pressure increased, the organization offered to put various incremental amounts (a maximum of \$100 million) into a fund. Finally, state regulators stepped in, identified assets of \$3.2 billion, and forced Blue Cross of California to set up two foundations to oversee the distribution of these funds back to the communities.

In contrast, when Georgia Blue Cross converted and also refused to create a charitable fund, the state's insurance commissioner agreed that none was necessary. There was no public pressure on government officials to see that a fund was set up until the process was completed and it was too late to do so. The affected Georgia communities got nothing to compensate for the loss of their nonprofit system.

Such conversions are occurring all over the country; the number quadrupled from 1994 to 1996. If the current rate of conversions continues, it is estimated that 450 to 500 nonprofit hospitals will convert to for-profit status. In communities in which no activists protect their interests and no official watchdog oversees the process, compensation is slight. By contrast, in communities where activists, legislators, and regulators step in, the average amount given back to the community is estimated at \$50 million. Therefore, everyone in the field of community development should be actively addressing the issue of conversion.

Beyond ensuring that the community receives its rightful compensation, community development groups should take active roles in the conversion process so they can have a voice in how the funds are spent. The switch to for-profit status has far-reaching

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effects on any community. The level of free care the hospital provides dwindles, expensive services are discontinued, and many community members who have been employed by the facility lose their jobs as the institution strives to increase efficiency.

By securing seats on the charitable foundation's board, community groups can help oversee the distribution of funding to make up for these losses. They also can ensure that the foundation funds the costs of the changeover and the technical assistance needed to accomplish the switch so that the community does not have to absorb these costs.

When community groups are confronted with this kind of conversion, they should

- use the threat of impending change to rally support from diverse sources that have an interest at stake, including patients, doctors, medical associations, hospital workers unions, and individuals or groups who might apply for grants from the new charitable foundation;
- use the idea of a common enemy to unify community groups that previously would not make the effort to cooperate with each other;
- empower a state or other official—for example, the state attorney general, insurance commissioner, director of the health department, or head of the department of incorporation—to act as a watchdog in all such conversions and to mandate the formation of a fund to reimburse the affected communities;
- demand public access to information concerning the conversion;
- demand public hearings and periods for public comment on the conversion; and
- ensure that the valuation of the not-for-profit facility or system (i.e., the determination of its worth) is accurate—for example, by stipulating that an independent financial expert conduct the valuation.

Health Systems Research, Inc.

Judith Gallagher

Ian Hill

Health Systems Research, Inc. (HSR), is a Washington-based firm that works with federal, state, and local health care financing and delivery programs to provide services such as health care policy analysis and development, evaluation research, and technical assistance. HSR has focused particularly on providing technical assistance in community services systems development.

Communities should look for several qualities in a technical assistance (TA) provider.

- Beyond having solid expertise in the relevant field, the TA consultant must be able to translate that expertise into practical actions that members of the community can undertake themselves. A consultant may be the world's leading expert on a given issue but may have no aptitude for sharing that knowledge with laymen or teaching them how to apply it. For example, a leading academician who knows everything about infant mortality but cannot tell the community how to tackle its own particular problems with infant mortality would not make a good TA provider.
- A good TA consultant goes beyond providing "off the shelf" assistance. Poor consultants simply deliver a standard product that has helped other communities with similar problems. A good consultant, in contrast, takes time to think about each community's particular situation and customize the product to fit its needs.
- The best TA providers are experts in group dynamics and conflict resolution. Often their most valuable contribution is in bringing together opposing elements within a group, facilitating overall change, and brokering contact between the community and another group that has solved a similar problem. Good TA providers help to manage meetings so that they do not become forums for endlessly rehashing the same issues.

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- As an outsider, the TA consultant can bring a fresh viewpoint to the situation. He or she often does not need to change a community's approach but can provide a valuable service by validating that the community is on the right track.
 - A good TA provider is in many ways a marketer for the community group. He or she can help motivate members of the community to pay attention to a particular issue and get excited about the possibility of improving their situation.
 - In addition to conducting a needs assessment, good TA consultants can interpret the results of the assessment and explain them to lay people. The best consultants are those who can simplify complex concepts to the media and thereby ensure favorable media coverage for the community.
 - Good TA consultants know their limits and are willing to back away from a project or bring in another expert if they are in over their heads.
 - TA providers should always establish objective benchmarks for evaluating the progress of the community's project over time and should be accountable for their own performance as advisers.

Together We Can Initiative

Mary Skelton Roberts

Martin Blank

The Together We Can (TWC) initiative helps communities and states to create comprehensive community-based programs for the benefit of children, youth, families, and neighborhoods. TWC has assembled materials to facilitate collaboration among the various participants in community-based programs so that their efforts succeed. Primary among these materials is a tool called The Grid.

The Grid includes a chart of the seven elements essential to the success of any community-based program. By answering questions about how their program compares with this

chart, members of the collaborative effort can mark their status on The Grid and determine their progress toward success. This tool thus helps collaborative organizations, from the smallest community groups to the most complex state agencies, to sort through the elements they need to achieve their goals, to identify those they have already accomplished, and to prioritize those they have yet to accomplish.

The process of individually and collectively answering the 102 questions on The Grid clarifies each participant's understanding and sets in motion a dialogue that includes all participants' perspectives. This process builds cohesion within the group and provides a framework for evaluating continued progress toward success. In addition, it provides a tool for focusing the community-based work.

The seven elements that TWC has identified as essential to the success of community-based programs are as follows:

- collaborative decision making, with input from all affected groups
- public support for the effort and its goals
- parent and neighborhood participation
- accountability for results
- comprehensive services, supports, and opportunities
- financial sustainability
- mechanisms to ensure that the leaders who emerge as the program develops can continue in their positions and acquire any additional skills they need

Before any community-development program can succeed and before it can even use The Grid to assess its status, TWC believes the community must already have in place four necessary factors.

- A diverse group of appropriate community members must be involved in the program and committed to improving outcomes for the targeted group.
- Community members involved in the program must feel mutual trust and shared ownership of the problems they are

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addressing. They must have shared values and must be able to work together.

- The community must have some social institutions that provide help and support to its members. These may include community development corporations, family resource centers, churches, schools, and local health centers.
- The community must have access to outside resources to assist with crisis intervention. This service is often provided by government agencies such as departments of social services, health, and mental health.

When TWC works with community-based programs, it provides both the materials described above and the expertise that those involved in the program need to use the materials.

National Training and Technical Assistance Center

Joyce Thomas

The Training and Technical Assistance for Family Strengthening program is a cooperative project between the University of Utah and the Center for Child Protection and Family Support. It is funded by the Office of Juvenile Justice and Delinquency Prevention of the U.S. Department of Justice. The project aims to disseminate information about exemplary family-strengthening programs throughout the country, helping to close the gap between the wealth of theoretical knowledge about preventing delinquency and the inability to prevent delinquency in practice.

The program disseminates information through a World Wide Web site that gives access to publications and literature reviews; national conferences on family strengthening; regional, intensive workshops that train community agency staff in how to replicate the best approaches to preventing delinquency; and direct technical assistance to community agencies.

Successful family strengthening programs include a number of elements.

- *Sufficient intensity of intervention.* A minimum of 45 hours of intervention involving parents is necessary before changes in behavior are noted.
- *Developmental appropriateness.* Programs must be geared to the developmental stage of the children involved. The best programs break down interventions as appropriate for ages newborn to 5 years, 6 to 11 years, and 12 to 18 years. Programs can effectively cover the entire age spectrum as long as they address each age group separately.
- *Achievement of behavior change.* Parent education programs may succeed in improving parents' awareness of what they should be doing and their knowledge of parenting issues, but they may not change parents' behavior. Only parenting skills programs that offer hands-on learning, the opportunity to practice newly learned skills, and immediate feedback have been proven to change parents' behavior.

Successful parenting programs must also address parents' personal problems. Friendships can be promoted among those who are socially isolated by including them in informal, nonjudgmental parent groups. Alternatively, parents whose primary difficulty is access to programs would benefit more from in-home services.

- *Focus on family relationships.* The public perception is that juvenile delinquency thrives on negative peer influences and that parents are powerless to combat peer pressure; even the professional literature focuses too much on the peer issue. Overlooked is the fact that a strong, positive relationship with a parent is a tremendous protective factor, even in high-risk settings such as neighborhoods where gang membership is ubiquitous. Programs that focus on improving communication, appreciation, respect, and understanding between par-

ents and children are the most successful at preventing delinquency.

- *Long-term participant retention.* Many programs that appear to be beneficial fail to retain participants; this failure is often excused on the grounds that the parents are too overwhelmed to take advantage of the program. However, if parents and children enjoy and benefit from a program, they continue to use it; programs that make a real connection with families report retention rates of 85 percent or more. To make attendance easier, programs should have flexible meeting times and provide “extras” such as transportation to meetings, meals or snacks, and child care for younger children.
- *Relevant, culturally appropriate program materials.* Written handouts are not useful to people who are illiterate or who cannot read English. Likewise, videos that show members of a typical middle-class, suburban white family having a quiet cup of tea together do not appeal to poverty-stricken rural or inner-city non-white families.
- *Professionally trained, experienced, culturally competent staff.* This requirement is admittedly hard to fulfill because the work is difficult and not well paid. Motivating qualified staffers to remain committed is key.
- *A rigorous assessment mechanism.* Program evaluation must determine whether the program accomplished its aims, used its resources effectively, and changed participants’ behavior.

Replication: Increasing the Return on Social Investment

Narcisa Polonio

Replication and Program Strategies, Inc. (RPS), is a national, nonprofit organization that was established to help promising social programs expand and be adopted in other communities. RPS offers to community-based social programs the technical assistance they need in planning, feasibility, assessment, organizational design, capacity building, research, and marketing.

Charitable foundations that fund community development programs recently began to recognize that many such programs fail when they attempt to expand from a single small operation. It also became obvious that the programs that succeed at expansion are not necessarily the best ones. RPS was established to ensure that the most worthwhile programs succeed at replication.



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Replication of successful existing programs is advantageous because it conserves resources. Transferring an existing program with a proven track record allows communities to devote their energies and funding to capacity-building rather than to creating a new program.

The process of adopting an established program to a community's own situation allows the people involved to carefully examine their problems and strengths and to fine-tune their problem-solving skills. It also encourages them to network with another community—the one where the program originated—that had similar problems.

Community development programs that seek to replicate would benefit from knowing the characteristics essential to successful replication.

- *Business expertise.* The people who developed the program—usually professors, researchers, or social workers—often are not the ones who should be in charge of replicating it. Their expertise is in developing the program, not in transferring it to other communities or building the infrastructure for a program network.
- *Proof of real-world success.* Many programs that appear to succeed fail to prove that they actually made a difference to the people they served. Those who run the program either fail to build in self-assessment or measure their success indirectly rather than by real-world results. For example, one program boasted that it enrolled 200,000 families in volunteer work. However, there was no evidence that this “success” made any difference to the families who volunteered or to the community they worked in.

Community development programs do not have to undertake complex and expensive evaluations to prove their success. In the foregoing example, the program simply added an evaluation step in which participating families recorded a brief account of what they gained

from volunteering and community representatives recorded how the volunteer work benefited the community.

In another example, a medical researcher who developed a prenatal intervention was able to provide overwhelming evidence, through clinical trials, that his program worked in diverse settings. Children of participating mothers were shown to be at dramatically lower risk of abuse and neglect and were healthier on several measures than the children of nonparticipants. This program is now being replicated in 20 American cities.

- *Adequate funding.* Successful replication cannot rest on small efforts to disseminate information. For example, Harvard University's school of government annually awards money to the most innovative and worthwhile community programs so that they can be replicated. However, most of the recent awardees did not successfully replicate. A close examination of the process revealed that the awards provided only enough money for the program developers to create brochures and to travel to make a few presentations. A larger investment was needed to ensure successful replication.
- *Accurate identification of essential program components.* Managers of community development programs often fail to include in their program descriptions seemingly inconsequential details that can make or break the entire effort.

For example, one parenting program's materials did not account for its unusually high retention rate (90 percent of the parents returned to weekly meetings for months at a time). The program representative explained that once they began providing dinners for participants, attendance improved from 30 percent to 90 percent. These meals should have been considered a mandatory component of the program, since they had such a tremendous influence on its success.

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Another program involving families of volunteers was floundering until it provided matching T-shirts carrying the program logo for family members to wear. This seemingly irrelevant factor boosted participation dramatically and should have been included as an essential component of the program's success.

- *Allowing adequate time for replication to take root.* Even the best social programs cannot be forced on unwilling or unprepared communities. Successful replication requires that the "receiving" community genuinely accept the program, and building understanding of and commitment to a novel approach takes time. Forcing the issue amounts to mandating the program, a mistake made with many ultimately unsuccessful federal programs.

Maternal and Child Health National Center for Cultural Competence

*Tawara Taylor
Diane Denboba*

The Maternal and Child Health Bureau's National Center for Cultural Competence was founded in 1995 to assist Title V programs in the design, implementation, and evaluation of culturally competent health care delivery systems for children with special health care needs. The center offers this assistance by

- maintaining a resource bank of articles, videos, publications, meeting proceedings concerning cultural competence and children with special health care needs, and a list of consultants with expertise in this area;
- providing on-site technical assistance so that maternal and child health programs and programs for children with special health care needs can assess their cultural competence; and
- holding national "train the trainer" workshops in which agency staff members who train their colleagues in cultural compe-

tence can themselves receive ongoing training.

To become more culturally competent, health care delivery systems that serve children with special health care needs must improve their understanding of cultural influences on the populations they serve and their knowledge of how culture affects people's perceptions of disability and illness. Acquiring these skills enables staffers to work more effectively in cross-cultural situations.

Common mistakes that organizations make in the area of cultural competence include the following:

- Relying on a single staff member to interact with people from a cultural community because that staffer is acquainted with the culture or shows rapport with the people. This practice leaves the agency vulnerable if the staffer's link to the community is jeopardized for some reason or if he or she leaves for a job elsewhere.
- Failing to appropriately equip a service center. Facilities that use toys or household implements must ensure that they are familiar and acceptable to the families they serve. For example, puppets and dolls should reflect the racial or ethnic background of the children who will use them.

One Head Start program provided cribs for babies to nap in during breaks from enrichment activities. However, because the babies in this ethnic group were accustomed to sleeping in slings and had never slept in cribs before, they were anxious and irritable and their parents were suspicious of the staff's ability to care for them.

- Failing to make people from all backgrounds feel welcome at the facility. Examples of this phenomenon include the labor and delivery ward for African-American women that was decorated with dozens of (donated) pictures of white babies, facilities decorated in a manner that

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is subtly exclusive of non-white or non-middle-class people, and a clinic for homeless children that was stocked with magazines devoted to home decor.

- Failing to appreciate the correct channels of communication for people from varied ethnic groups. In another Head Start program, the mother of a child who appeared to have significant developmental delays was not responding to the teacher's requests for a developmental evaluation.

When the teacher encountered the family in the neighborhood, the father was walking empty-handed while the mother, laden with groceries, followed behind. The implied criticism in the teacher's reaction spurred the family to withdraw from the program entirely. Only then did the teacher realize that the mother had considered it inappropriate and disrespectful for her, rather than the child's father, to be asked to make the decision about an evaluation.

- Failing to include several people representative of the target population as board members of the provider organization or agency. Community representatives should reflect the population's ethnicity, socioeconomic status, and other characteristics. They must be made comfortable enough to remain on the board and to actively participate in its activities.
- Failing to hire staff that reflects the population served. "We can't find any African-American physical therapists" and "We can't find any Native American speech pathologists" are typical arguments that are used to defend ineffective employment outreach efforts. Most professional associations can readily direct potential employers to their members who belong to minority groups; indeed, most mainstream professional associations have Latino, Asian-American, African-American, and Native American offshoots.

Concurrent Sessions III: Showcase of Innovative Programs

Baltimore City Healthy Start Program

Thomas Coyle

Community Profile

East and West Baltimore, each of which has about 20,000 people located within a 1.5-square-mile area, are the poorest areas of the city. Rates of low and very low birthweight are high, as are rates of substance abuse among women of childbearing age. Many young mothers fail to finish high school.

Community Systems-Building Effort

The Baltimore City Healthy Start Program began in 1992 as one of 15 large HRSA-sponsored pilot projects. At the end of the original 5-year grant, the program received a funding extension.

The project is run by a private, nonprofit corporation that was set up to administer the project's funds. Although the project is accountable to Baltimore's mayor, it is not a city agency and it does not have to go through city government channels to get what it needs.

The Baltimore project uses service integration as a means to an end. It has established two "one-stop-shopping" centers—one in East Baltimore, one in West Baltimore—for women who are at high risk for poor neonatal outcomes. Women enrolled in the Healthy Start project receive a combination of center-based services and home visits. Healthy Start's credo holds that prenatal care is not enough to improve pregnancy outcomes for high-risk women. The project also tries to address issues of poverty, housing, unemployment, and racism.

Going door to door, outreach workers seek out women living in the target areas who are

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pregnant or who have babies under 6 months of age. An estimated 95 percent of the eligible women have been identified and enrolled. Case managers arrange for newly enrolled women to come to the center for a comprehensive needs assessment that becomes the basis for an individualized case-management plan.

Healthy Start's first priority is to solve the women's most urgent problems. The project will buy diapers and milk, pay the electricity bill, buy a refrigerator, and even pay overdue rent to prevent eviction. Once such emergencies are resolved, women are more likely to keep their appointments with Healthy Start staff.

A woman coming to the center can receive referral and transportation to prenatal and pediatric care and substance abuse treatment, child care for her children while she is at the center, daily support groups, parenting and nurturing classes, breastfeeding education and support, GED classes, nutrition education and cooking classes, and a hot meal, among other services. Each center has a staff of about 100, including professional case managers and addiction specialists. Most staff members are people from the neighborhood.

The Healthy Start project collects and evaluates its own data. The rate of very low birthweights has declined by 65 percent in the target areas of Baltimore since the project began; infant mortality has declined by 35 percent.

Within the Baltimore Healthy Start project is a pilot project for 200 fathers, almost all of whom have been in prison, sold drugs, and used crack cocaine or heroin. The fathers are offered enrollment in residential drug treatment. In addition, the center holds one weekly meeting for the men on parenting, nurturing, and conflict resolution and a second in which they help each other solve their problems. Once a father has been certified to be drug-free and healthy, he is guaranteed a paid job in construction for 1 year. About 50 percent of the fathers hold the job for the year.

The Baltimore City Healthy Start Project has received \$40 million in funding over its 5-year existence. An economic savings model demonstrates that preventing the birth of a very-low-birthweight infant saves the city \$63,000 in associated hospitalization costs alone. The project director hopes to convince Maryland's governor to split those savings with Healthy Start to make the program self-sustaining. Data confirming such savings are useful in convincing managed care plans to adopt the Healthy Start model.

The family planning offered as part of each center's services is called Life Planning. Women are taught that birth control, like education and employment, is part of having control over their lives.

Mercy Children's Health Outreach Project

Catherine Kelly

Community Profile

Mercy Medical Center is located in Baltimore's central business district. Lacking a residential neighborhood to serve, the hospital "belongs to everyone," including the city's homeless. Children living in the city's homeless shelters are the focus of the project.

Between 400,000 and 3 million Americans are homeless at any given time. The average age of the subset of the homeless who live in shelters is 30. Forty-five percent of shelter residents are unaccompanied men, 40 percent are members of families, 25 percent are children and youth, 44 percent are African American, and 42 percent are non-Hispanic white. Fifty percent of the women and children living in shelters are fleeing domestic violence. Fifty percent of the homeless in shelters suffer from mental illness, 50 percent are substance abusers, and 20 percent are employed.

Community Systems-Building Effort

In 1996 the Mercy Medical Center received a grant from the Maternal and Child Health Bureau to run the Mercy Children's Health

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Outreach Project (MCHOP). From 1991 to 1996 the University of Maryland at Baltimore had run this program, then known as the Baltimore Homeless Children's Project, which had begun under a grant from The Robert Wood Johnson Foundation.

MCHOP provides health care, case management, social work, and referral and advocacy services for children living in the city's homeless shelters. MCHOP's staff includes two full-time pediatric nurses, a pediatric social worker, a part-time project director, and a volunteer medical director.

Other members of the coalition are the University of Maryland at Baltimore; Health Care for the Homeless; the House of Ruth; the YWCA; the Salvation Army; the Episcopal Social Ministry; the homeless unit of the Baltimore City Department of Social Services; the Girl Scouts; Baltimore City public schools; the Women, Infants, and Children program; and Action for the Homeless.

The coalition has no officers, no bylaws, and no section 501(c)(3) status. Its mission is to make things happen for homeless children. Examples of the coalition's achievements include the following:

- Establishment of a residence and respite program for the children of homeless women who are undergoing detoxification for substance abuse
- Provision of reasonably priced, MCHOP-owned housing to women who successfully complete the substance abuse treatment program
- Mercy Medical Center's purchase of a service contract to provide pediatric nurse practitioners to the YWCA's therapeutic nursery for homeless infants
- An informal arrangement by which every homeless shelter in Baltimore agrees either



to have MCHOP assess the health of its child residents or to consult the program on case management and referrals for these children

In the project's first 8 months, MCHOP saw 572 homeless boys and 1,000 homeless girls, most of whom were under age 12 and 90 percent of whom were African American. The most frequent health complaints were asthma and otitis media. Seventy-six percent of these children lived in a city shelter, 12 percent were doubling up with another family, and 6 percent lived in transitional housing.

The funding agency has not yet defined outcome measures. However, Mercy Medical Center is looking at some outcome measures of its own, such as immunization rates (which are high among these homeless children). Also being looked at are how many children had a primary care provider before they became homeless and how many of those providers would accept referral of that child back to their practice. Those figures are not

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yet known, but primary care providers are known to be skittish about continuing to care for children when they become homeless.

Michigan Public Health Institute

Christina Patterson

Charles Maynard

Community Profile

The state of Michigan is in the midst of an effort to increase collaboration within and among community departments of public health. The communities served by this project are ethnically diverse, urban and rural, affluent and impoverished, and located throughout the state.

Community Systems-Building Effort

The Michigan Public Health Institute (MPHI) is a nonprofit institute founded in 1990 by four partners: the Michigan Department of Community Health, Wayne State University, Michigan State University, and the University of Michigan. With the formation of MPHI, Michigan became only the fifth state to provide technical assistance to communities trying to collaborate in the interests of public health. In 1990, other states with such programs were New York, California, Massachusetts, and Texas. The partnership has led to collaboration on projects that none of the partners could have carried out alone.

Formation of MPHI required enabling legislation to allow the state to participate in such an arrangement. MPHI acts as a sole-source contractor and thereby avoids normal procurement procedures. All funding that MPHI obtains from the state is considered a grant rather than an appropriation.

MPHI has a governing board of directors. Chair of the board is always the director of the Michigan Department of Community Health. The 12-member board comprises 6 representatives from the three participating universities, 4 from the Department of

Community Health, and 2 from foundations based in the state.

MPHI has built a state-of-the-art learning center complete with the latest in communications and computer technology. The large computers at MPHI can run large databases. Rural and other communities can exchange ideas in teleconferences conducted over MPHI equipment.

MPHI considers its mission to be that of a neutral convener that can promote improvements in community health by helping communities collaborate. The state of Michigan used to do some of this work, but MPHI can act more quickly because it is unimpeded by cumbersome state government requirements. MPHI helps convey the communities' needs to the state and helps local communities to understand the state's technical jargon, legislative language, and complicated technology.

MPHI offers a community health leadership institute where community public health advocates can hone their leadership skills. With that training, community leaders have gone on to initiate local public health projects, such as a childhood immunization registry in the southeast region of the state that has significantly improved childhood immunization rates. Another project analyzes child death certificates and tells the state what programs are needed to reduce accidental deaths among children.

MPHI's budget has gone from \$300,000 when the institute received section 501(c)(3) status in 1992 to \$14 million in 1996. Its original staff of 3 has grown to 120. At present, 100 percent of MPHI's funding is "soft money" (from either the state or foundations), but the institute is looking for alternative sources of funding.

Some state employees view MPHI as a competitor for money and jobs. These attitudes interfere with MPHI's ability to form collaborative relationships in communities. MPHI has privatized some state government services, which put some state employees out of work. Because MPHI now receives some state

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funds that used to go to other nongovernmental organizations, it is regarded by some as being greedy.

Local politics make it difficult to work at the community level. The work is time-consuming and requires patience.

Ready 2 Work: Family-Centered Community Transition Services

Kris Schoeller

Community Profile

About 100,000 children with disabilities live in the state of Minnesota. Their disabilities range from chronic health problems such as asthma, diabetes, and cystic fibrosis to seizure disorders, autism, mental retardation, and psychoses. Traditionally, high schools have done little to prepare these children for future employment. As a result, many disabled teenagers get into trouble: 40 percent become parents within 3 years of finishing high school; 70 percent of incarcerated adolescents were in special education programs in high school.

Survey data have shown that most parents want their disabled teens to have a job and that most disabled adolescents want to work. Some employers are willing and eager to hire workers with disabilities but do not know how to go about doing so.

Community Systems-Building Effort

The Federal Rehabilitation Act of 1973 was amended in 1987 to mandate that states provide the training and services necessary to enable people with disabilities to work and live independently in their communities. The amendments stress that disabilities are a natural part of the human experience and in no way diminish a person's right to self-determination, independent living, and the pursuit of a meaningful career.

The St. Paul-based Project for Family-Centered Community Transition Services (FACCTS) is in the first year of a 5-year grant from the Maternal and Child Health Bureau to help disabled teens make the transition

from school to employment. For 8 years, under an earlier grant, project staff surveyed families with disabled children about their transition needs. Most respondents requested more information about jobs for their children. Although there is a great deal of such information, families did not know where to go for it or how to use it.

FACCTS staff worked with the St. Paul public schools to develop a curriculum focused on planning for the future, developing self-advocacy and stress management skills, and confronting health and sexuality issues. Nurses from the St. Paul public schools subcontract with FACCTS to provide individualized education for teens who have chronic diseases or disabilities on how to manage their own care and employment.

The time of transition from school to career is almost as overwhelming for families as is the time when a child is diagnosed as disabled. Project FACCTS adopted the model of the early childhood services coordinator to help families deal with this transition. A coordinator sits down with each family and describes the job-training opportunities and independent-living arrangements that are available. In addition, coordinators help families to negotiate the various agencies that have something to offer their child.

Project staff members work with each family to develop a transition plan that reflects the family's values and the teenager's interests, strengths, and dreams. Sometimes staff members must help the family learn to look at the disabled teenager as a whole person and accept job training as a viable alternative to remedial services.

St. Paul contains many families of African-American and Southeast Asian ancestry. The project employs two part-time outreach workers, one African American and the other Southeast Asian, to meet the needs of those populations. The project also has two full-time staff members.

Transition services were designed using input from parents and teenagers. Project

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FACCTS offers videos and training for disabled teens on performing the skills of daily living, budgeting money, understanding their rights under the Americans with Disabilities Act, and protecting themselves from crime. In addition, because many parents wrongly view a disabled child as asexual, Project FACCTS offers information about healthy sexual development in teens.

FACCTS staff members work with potential and current employers to help them understand how a teen's disability might affect his or her job performance. Staff members also work with disabled teens to help them understand how their health affects their job, relationships, ability to live independently, and other aspects of transition.

Project staff members are developing a database of job opportunities and volunteer activities that have been screened and proposed by families of youth with disabilities.

Comprehensive Community Health and Services Program of Project Vida

Bill Schlesinger

Community Profile

Project Vida serves residents of the 79905 zip code area in El Paso, TX. The city is located on the Texas-Mexico border and is a primary port of entry for both legal and undocumented immigrants. Ninety-nine percent of the population is Hispanic. The median age of the 12,000 residents of the project area is 15 and the median income is \$7,000 for a family of four. The garment industry had been the area's traditional employer; however, many of those jobs have moved to Mexico.

The rate of violent crime in the project area is three times that of El Paso as a whole. Gangs are ubiquitous, having been part of the community for four generations. Sixty-five percent of adults 25 years of age and older have less than a ninth-grade education. Crowded, dilapidated housing is the norm:

more than 500 families are doubled up in apartments or single-family homes.

The project area is a federally designated Medically Underserved Area and a Health Professional Shortage area. Only a minority of the residents have medical insurance. Families tend to use the emergency room of the nearby county hospital as their source of primary care.

Community Systems-Building Effort

Project Vida, a private, nonprofit agency, began in 1990 when Bill and Carol Schlesinger used a \$40,000 gift from the Presbyterian Church to buy a small house in the community. They began slowly to gain the trust of members of the community through coffee hours at their home.

Four areas of obvious need became apparent during those discussions and follow-up home visits: access to primary health care, more and better housing, education, and gang prevention. The Schlesingers opened a tiny clinic that was staffed by a volunteer retired physician and was open one night a week.

With other grants, the Schlesingers expanded the clinic; its staff now numbers 60. Services provided by the clinic include immunizations; Early and Periodic Screening, Diagnostic and Treatment Program (EPSDT); cancer screening; WIC services; health education; pediatric care; family planning; dental care; corrective lenses; women's health; targeted case management; and home visiting.

In response to needs identified by a community congress, Project Vida worked with local agencies to develop programs for the 1,200 families registered with the project. Other services offered by Project Vida—a 1996 recipient of HRSA's Models That Work Award—include housing, education, youth recreation activities to counter the influence of gangs, and a full range of social services.

A marked developmental delay noticed among the children of families in the community was traced to crowded living conditions. Rather than stimulating their children, moth-

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ers were keeping them in car seats and using bottles of sugar water to keep them quiet.

The project's budget totals \$1.2 million, with funding coming from the Texas Department of Health, AmeriCorps, a Community Development Block Grant, the Presbyterian Church, the El Paso Community Foundation, and the Maternal and Child Health Bureau. These agencies serve as Project Vida's partners, as do Thomason Hospital, the City-County Health District, the El Paso Cancer Consortium, the Family Pride Collaborative, the City of El Paso's Community Development Department, the Case Management Association, Sierra Optical Company, and Project Ayuda.

Because it was met initially with distrust, Project Vida had to move slowly toward its goal of a collaborative approach to meeting the community's needs. Old feuds that had stalled community cooperation for years had to be bypassed for change to occur. Project staff eventually achieved a community coalition by maintaining that conflicts could be resolved because most people want to be useful, creative, and part of the solution to their community's problems.

Vermont's Comprehensive, Community-Based System of Care for Children and Adolescents

*Paula Duncan, M.D.
Nancy Frank*

Community Profile

One-half million people live in Vermont, one of the country's two most rural states. Vermont has 14 counties and only one metropolitan area, Burlington. Of the state's 255 towns and cities, only 7 have populations greater than 10,000. The state's median income in 1995 was \$34,000.

Between 30 and 40 percent of the state's children receive Medicaid, which is available to all children from birth to age 18 who live at or below 225 percent of the federal poverty

level. Only 4 to 6 percent of children in Vermont are uninsured. Medicaid also extends to pregnant women living at 200 percent of the federal poverty level.

Eight of the state's 14 counties have severe shortages of primary care physicians, but because the state is small and close to New Hampshire, some of these areas do have reasonable access to health care. The state's generous Medicaid eligibility standards mean that most residents have some form of health insurance.

Community Systems-Building Effort

Six years ago, an advisory group told the Vermont Agency for Human Services that the only way to learn anything meaningful about the access of children and youth to primary care health services was to assess data gathered at the community level rather than the state level.

Vermont received a State Systems Development Initiative (SSDI) grant from HRSA 5 years ago and has been awarding the money to communities to assess the resources they need to improve health care for children and teens. The first step was to develop a survey of indicators associated with good health: graduating on time from high school, living substance-free and violence-free lives, wearing safety belts and helmets, and developing healthy sexuality. Once each community identified its areas of strength and its needed resources, it then developed projects to provide those resources.

Each of the 12 health department regions has a team charged with coordinating and implementing programs in the community. These regional teams work with a state team made up of representatives of the departments of education, health, mental health, and human services. The regional committees meet monthly to receive reports from the five subcommittees concerned with parent involvement, outcomes and indicators, professional development, fiscal issues, and service coordination.

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The town of Randolph, population 6,500, took 6 months to conduct its survey and develop goals. Survey findings showed that 98 percent of children had a primary care provider but 50 percent did not have dental care. Of those people using mental health services, nearly half were dissatisfied with its cost and with the comfort of use. The youth surveyed expressed disappointment with after-school and summer activities.

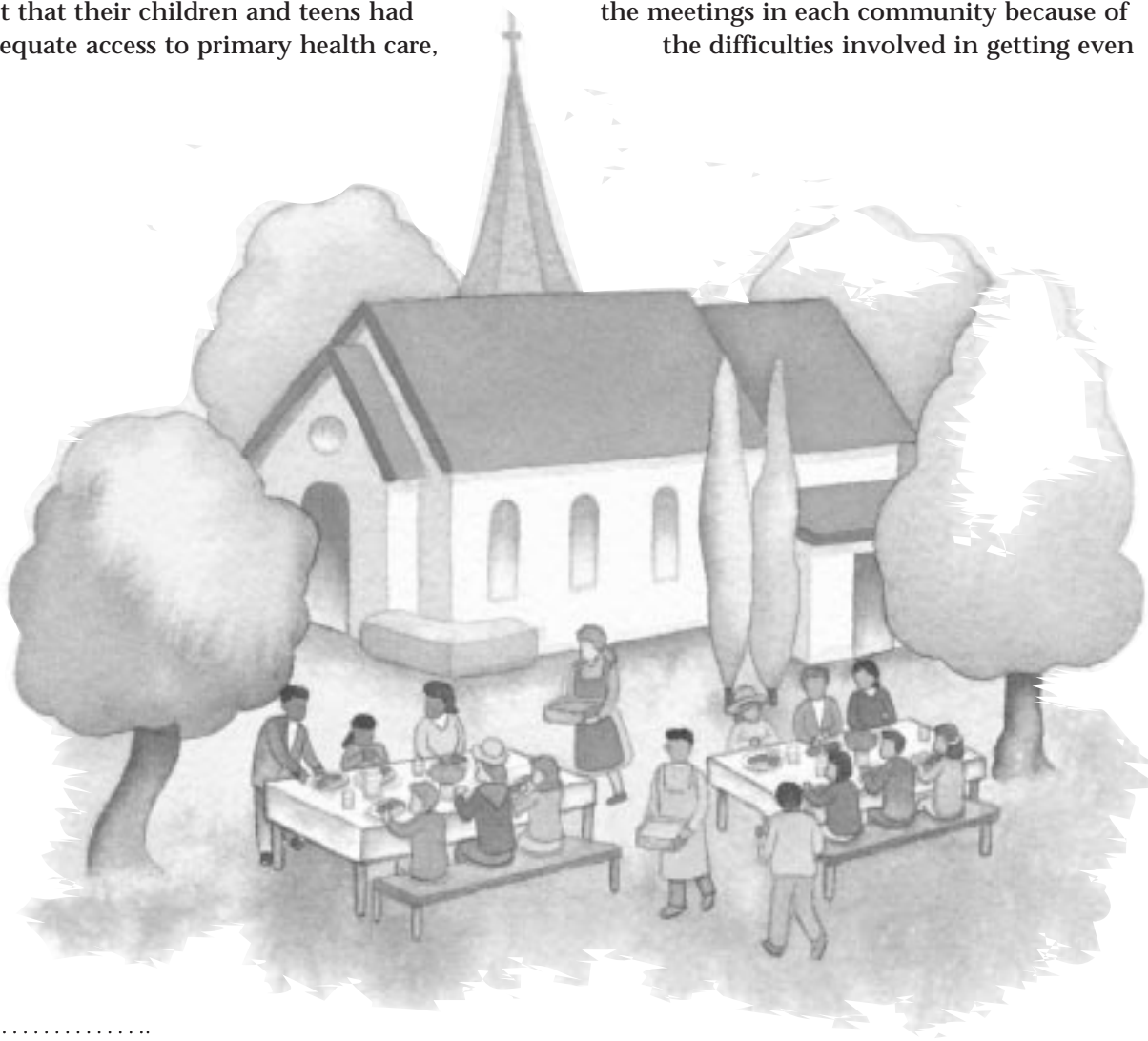
In response, the Randolph Community Development Corporation developed a summer program for youth to build trails. In addition, the corporation converted an abandoned building into a one-stop-shopping center where five agencies share space and staff to provide comprehensive services for children.

Residents of the town of Middlebury felt that their children and teens had adequate access to primary health care,

but parents did not know what other services were available for children and teens and how to find them. Acting on that concern, the school nurse stopped screening the children—something that the local pediatrician was also doing—and began to help families find the social services they needed.

Each community received \$6,500 to assess the health status of its youth. Because some communities spent much of that money on data analysis rather than community forums and focus groups, health departments may take over the data analysis. The Robert Wood Johnson Foundation provided some of the funding for this community-based approach to caring for children and teens.

The state has several important roles in the process. First, it has initiated and organized the meetings in each community because of the difficulties involved in getting even



the most public-spirited community representatives to sit down together. In addition, the state works with the community to decide how best to use the SSDI funds and what to do with any savings. The state also holds educational forums.

One roadblock to the process has been resistance among members of some communities to sitting down together to assess the needs of their youth. Another has been the difficulty of making the data user-friendly.

Group Presentations

NOTE: The following workshops were presented in Concurrent Session I and repeated in Concurrent Session III.

Serving Children with Special Health Care Needs and Their Families: Washington State Systems-Building and Services Integration Activities

Washington State Community Health Care Project

Heather Hebdon

Interactive Video Teleconferencing in a Community-Organization Care Network

*Karen Sizemore
Jo Ann Jennings, R.N.*

Community Profile

Washington State has a diverse population of almost 5 million residents, including large numbers of African Americans, Asians, Hispanics (the fastest-growing minority group), and Native Americans. The state's migrant population comprises 115,000 residents from a variety of cultures. In addition,

Washington State has the fourth largest military population in the United States.

Geography is a significant fact of life: The Cascade mountain range bisects the state, causing a distinct "east side–west side" mentality. Most of the state's population lives in three counties on the west side of the mountains, where numerous resources are available for children with special health care needs. In addition to three children's hospitals, the Mattigan Army Medical Center serves many military children. Schools and other organizations provide a variety of opportunities for early intervention.

On the eastern side of the state, however, as well as in rural areas on the western side, resources are far more limited. Many rural residents lack transportation or are reluctant to take their children to large cities to receive services. Seasonal workers often cannot afford to lose wages or pay for travel costs. Even for those willing to travel, mountain roads are often impassable during winter months. As a result, many families go to Idaho and Oregon for services they cannot reach in Washington.

Community Systems-Building Effort

In such a culturally and geographically diverse state, assisting children with special health care needs and their families presents special challenges. The two projects described in this workshop use collaborations and technology to bring services to underserved segments of the population.

Washington State Community Health Care Project

A part of Washington Parents Are Vital in Education (PAVE), the Community Health Care Project provides services and support to families who have children with special health care needs. A collaborative effort, with links to a variety of sources, the parent-run and parent-directed organization serves families who access services through managed health care systems.

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PAVE received its initial funding in 1980 and began work with a staff of four volunteers. Now it has an annual budget of more than \$500,000 and operates 13 projects. The Community Health Care Project is in its third year of funding from the National Parent Network on Disabilities. Services provided include early intervention and mental health programs. In addition, one project works with U.S. military families both in this country and overseas to assist children with special health care needs.

To facilitate parent-to-parent support, project leaders hired staff who are themselves parents of children with disabilities. The multicultural, multilingual staff is dispersed throughout the state. Initially, most members of the project advisory committee were professionals, but now parents form a majority.

The project has linked with county and state parent-to-parent groups to share resources and conduct joint training, and it has also worked with a state and national fathers' network. Staff members and parents have made presentations to medical personnel to develop additional relationships.

The project has memoranda of understanding with more than 300 organizations to disseminate information through a quarterly bulletin. The project also has placed families on planning boards throughout the state to help influence decision makers.

To deal with the state's cultural diversity, the project has collaborated with foreign-language radio stations that serve Hispanic and Asian communities. Because some immigrants are illiterate even in their native language, many of them fail to access services such as Medicaid. To increase participation, project staff members have appeared on talk shows to provide information about the services available. The radio stations have helped by advising the project staff of issues and trends in the communities they serve.

Collaboration and cooperation have made the project successful. Many of the project's

resources have extensive connections, so initial contacts with families may come from a variety of organizations. Families have discovered that they have culturally appropriate support and resources to meet the special health care needs of their children.

Interactive Video Teleconferencing in a Community Organization Care Network

In isolated, rural, culturally diverse areas of Washington state, families of children with special health care needs often have limited access to secondary and tertiary pediatric consultative resources. The Interactive Video Teleconferencing (IVTC) project was developed to provide these families with access to such specialist services.

Funded through the Maternal and Child Health Bureau, the project uses interactive video teleconferencing technology to "bring" specialists to remote areas. IVTC consultations give families more comprehensive information and enable local providers not only to expand their knowledge but also to provide higher-quality care to their patients.

A variety of factors led to the development of the IVTC telemedicine network.

- Children's Hospital in Seattle is the only comprehensive, multidisciplinary, pediatric care center serving the five-state region of Washington, Wyoming, Alaska, Montana, and Idaho (WWAMI).
- The Cascade mountain range dividing the state presents both geographical and psychological barriers to travel.
- Medicaid pays to transport only one parent and the child to a consultation with a specialist. Siblings left at home may lack adequate supervision, and the other parent is not at the consultation to participate in decision making or to help deal with the stress of a discouraging diagnosis.
- The local provider is not present at the consultation, and information exchange before and after the consultation is often limited.

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- Providers had to travel by ferry to hold clinics for Native Americans who lived across Puget Sound.

Because it crosses state lines, telemedicine must resolve a variety of medical and legal issues. However, WWAMI provides the legal authority for specialists to provide consultations across the five-state region. (The specialists currently do not charge for their services.) A local provider is with the family during the consultation.

The IVTC project team is working to implement the network over a six-county area. The counties vary significantly in terms of population, ethnicity, and economic status. In 1996, the project team saw 1,121 children with special care needs, 681 of whom lived at or below 100 percent of the federal poverty level. Many of the communities served possess a variety of providers, ranging from nurse practitioners to pediatricians, whereas others have no providers.

Interactive video is not a suitable format for all consultations, but it is quite useful for discussing behavioral issues, care management, and follow-up. IVTC is also reassuring for parents who want a second opinion.

IVTC has been well received. Parents generally adjust to it by the second session, and children love it. Other local providers often sit in on the consultations (with the parents' permission), expanding the educational scope of the consultation. Closely affiliated with the University of Washington, the IVTC network is also being used for interactive video training of teams at participating hospitals.

The IVTC system requires an IBM-compatible 486 (or faster) computer, and it uses software from Share Vision for Creative Labs and Picturatel. The number of sites at which IVTC can be offered is limited because of the need to install fiber-optic lines.

Besides resolving legal issues, the project needs to find a way for specialists to bill for the time they spend on telemedicine consultations. The state government has announced

that Medicaid will begin reimbursing for telemedicine consultations in January 1999. Most of the children "seen" via telemedicine consultations are funded through Medicaid.

Enhancing Access and Capacity Through Nontraditional Providers: Wisconsin State Systems-Building and Services Integration Activities

Wisconsin State Systems Development Initiative

Irene Sandvold

Colleen Cantlon, B.S.N, M.Ed.

53212 Perinatal Partnership

Bill Solberg, A.C.S.W.

Wisconsin Area Health Education Center

Susan Tillema, M.S.W.

Marquette University College of Nursing Nurse-Midwifery Program

Leona VandeVuss, C.N.M., Ph.D.

Community Profile

Wisconsin is a fairly conservative state in terms of health care. For example, nurse-midwives handle fewer than 3 percent of births in Wisconsin compared with about 5 percent nationally. In rural areas of the state, health care providers are difficult to attract and retain. Of the four programs discussed in this workshop, three operate in both urban and rural underserved areas.

The fourth program, the 53212 Perinatal Partnership, serves the 53212 zip code area in Milwaukee. This impoverished area once had plentiful blue-collar jobs, but problems devel-

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oped as many of those jobs disappeared. The infant mortality rate rose to more than 18 percent, almost double the state average. Barriers to prenatal care include lack of insurance; anxiety about dealing with institutions, particularly the welfare department; poor infrastructure; a shortage of doctors, especially primary-care practitioners; poor nutrition; and lack of a local WIC clinic.

Community Systems-Building Effort

The presenters called this workshop “Making Community Happen.” They defined three strategies that had been used in all the projects, programs, and grants as

- the enabling and support of systems at the local level,
- the promotion of public and private partnerships, and
- attention to financial and sustainability issues.

Individually and collaboratively, the programs have improved maternal and child health care in Wisconsin.

Wisconsin State Systems Development Initiative

The State Systems Development Initiative (SSDI), a 6-year program, resulted from a grant that Wisconsin received from the Maternal and Child Health Bureau in 1993. Now in its fifth year, SSDI has an annual budget of \$6 million. The program has thus far spent \$30 million on state systems-building initiatives.

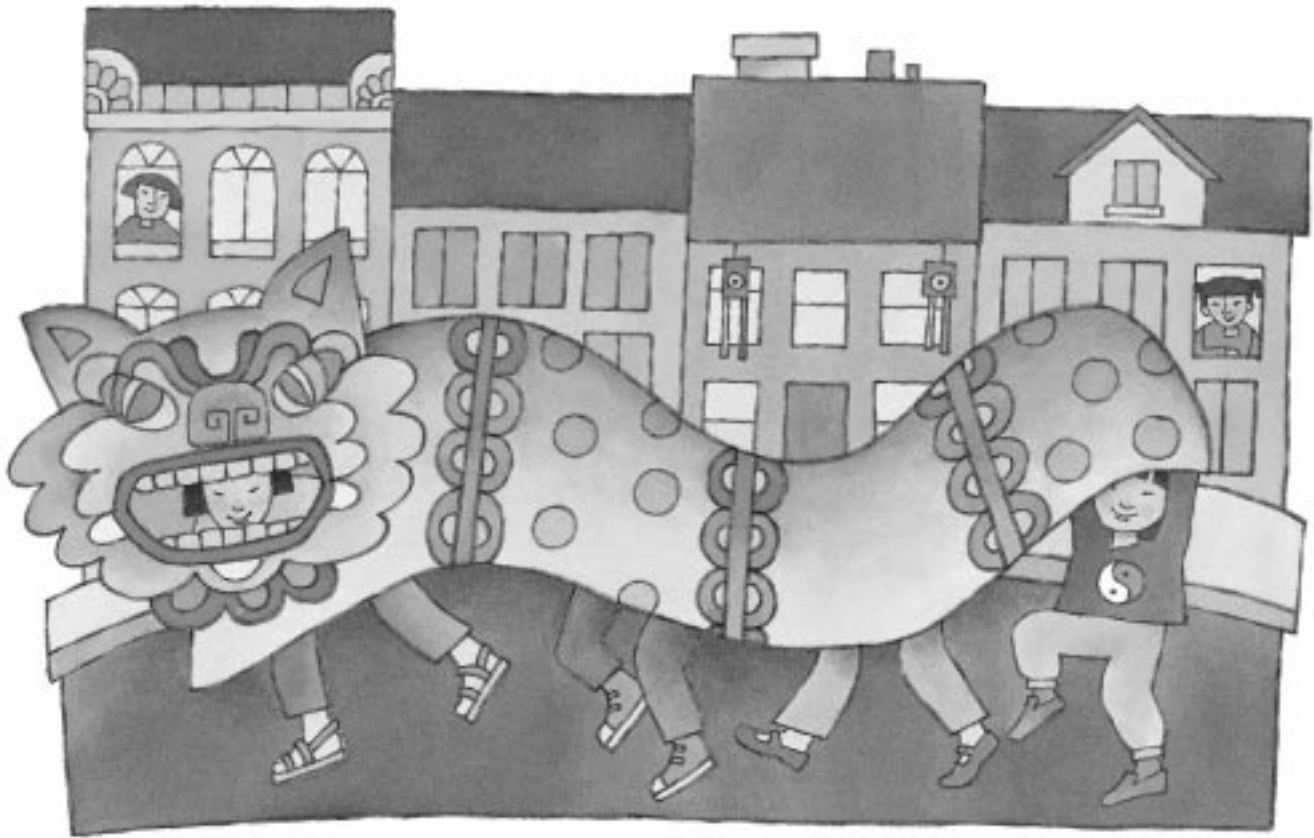
SSDI’s central goal is to increase the leadership capacity and infrastructure of the state’s MCH program. Because the program’s funding did not provide for additional state employees, the positions were subcontracted to the Wisconsin Area Health Education Center system. This valuable partnership has facilitated collaboration with other state-level agencies and entities.

Several factors have contributed to the success of SSDI.

- During a 2-year planning process, five guiding principles were adopted that have provided guidance for all MCH programs in Wisconsin and are considered a unifying factor in collaborative efforts.
- The selection of Total Quality Management (TQM) as a uniform management approach complemented the five guiding principles—particularly TQM’s attention to customers. MCH nurse leaders, program staff, and steering committee members receive extensive TQM training, ranging from 2-day courses to a year-long leadership institute.
- A federal site visit in November 1993 brought 22 people from various government agencies to take a systems-focused look at the Wisconsin programs (unlike earlier service-focused visits). A resulting 200-page report provided extensive guidance for ongoing systems development.
- The MCH program, part of the Bureau of Public Health, has developed a strong partnership with the state Medicaid program.
- The Milwaukee Common Ground Project brought some unlikely but essential partners to the systems-building effort. Among these are MCH leaders, private foundations, executives of managed care organizations, churches, and other community leaders.
- The Milwaukee Healthy Women and Infants Project has united health professionals, community organizations, and residents of the central city in the project’s implementation, planning, and ongoing activities.
- The Bureau of Public Health developed a document, “System Indicators: Development of Community Performance Measures,” that provides a community assessment framework for the systems.

53212 Perinatal Partnership

The 53212 Perinatal Partnership is funded through the Community Integrated Service Systems (CISS) program. Now in its fifth year, the partnership receives approximately \$10



million annually through a set-aside in MCH Title V funding. The partnership is MCH's attempt to give pilot programs flexibility in developing systems to improve maternal and child health.

The partnership has focused on three general issues.

- *Prenatal education.* Success has depended on getting hospitals and other groups to work together.
- *Community health workers.* These workers have been crucial in helping women to overcome barriers such as lack of transportation and insurance.
- *Improving systems of care.* To be effective, systems had to be integrated at all levels.

In addition, the partnership has developed several innovative programs.

- Many qualified residents avoided dealing with the welfare department, which deter-

mined eligibility for MCH programs. The partnership brought welfare personnel into the hospitals and stressed courtesy and respect to applicants, thus overcoming a major barrier. (The "show" rate climbed to 85 percent.)

- The partnership worked with the state to create a local WIC clinic.
- Working with churches, the partnership developed parish nursing relationships. Nurses provided prenatal education in their own churches, thereby creating stronger relationships with residents.
- Working with the local high school, the partnership developed school, work, and career programs to provide students with realistic goals, in the hope of reducing premature sexual activity and other dangerous behaviors. Working with the state, the partnership is creating a program of school-based health clinics and a program to fund uninsured students.

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- The partnership has worked with the Wisconsin Area Health Education Centers system to bring medical residents and nursing and social work students into schools to do family visiting and hands-on work.
 - The local hospital developed a stronger presence in the community to provide a healthy-community focus.

The CISS grant ended in October 1996. However, state strategies (such as SSDI, case management, and Healthy Start expansion) came to life at a local level, helping to sustain the partnership's efforts.

Wisconsin Area Health Education Centers

The Wisconsin Area Health Education Centers (AHEC) system, funded by the Bureau of Health Professions, began in 1991. A regional system of health education, AHEC is designed to increase the supply and improve the distribution of health professionals through community-based education programs for health professionals.

AHEC forms collaborative alliances with like-minded organizations throughout Wisconsin. These partnerships enable communities to provide culturally relevant, multidisciplinary education programs with a focus on minority students and the needs of underserved urban and rural areas.

Additionally, AHEC supports medical students as well as students in nursing, physician assistance, dentistry, pharmacy, and other health-professional education programs. AHEC also supports community education centers that link academic faculty with preceptors (local practitioners) who mentor students.

A major AHEC program is WIS-TREC, which is funded by a 6-year grant from The Robert Wood Johnson Foundation. This program is designed to develop community-based, "grow-your-own provider" opportunities for nurse-midwives, nurse prac-

tioners, and physician assistants. Key WIS-TREC activities include the following:

- recruitment of potential students
- encouragement of employers in underserved areas to use nonphysicians as prime sources for primary health care
- development of innovative models of distance education

AHEC works with both rural and urban employer partners. One such partner is Marshfield Clinic, a rural provider that hopes to increase retention of providers in its clinics. Another partner is Aurora Health Care, located in the Milwaukee area, which is hoping to increase its pool of providers.

AHEC has enjoyed a strong partnership with the Wisconsin Bureau of Public Health (BPH), receiving five grants thus far. One AHEC program funded by BPH is the Maternal and Child Health Education and Training Institute, which provides training at both the professional and community levels, particularly in implementation of the MCH guiding principles. The institute offers educational opportunities in diverse formats, such as via satellite, and is exploring compressed video and distance learning. It also pursues diverse collaborations and maintains an extensive lending library of MCH resources and materials.

SSDI has acted as a broker in encouraging public health regions to develop collaborative training programs with AHEC offices.

Marquette University College of Nursing Nurse-Midwifery Program

Marquette University's nurse-midwifery program, started in 1993, is the only such educational program in Wisconsin. Funded by the Bureau of Health Professions, the 2-year, full-time program grants master's degrees.

As a private university located in central Milwaukee, Marquette's focus is primarily urban. However, the nurse-midwifery program also places students in underserved rural areas. AHEC seeded the program with financial support, encouragement, networking, and

other help and continues to be supportive. WIS-TREC has also provided funding, involved all of the program's faculty, and increased the program's visibility.

The program has worked with the state medical society and nursing associations to encourage joint dialogue. Physician consultants have also been supportive. The program's advisory group includes members from several MCH communities. The group provides advice on ways to build the program, such as minority recruitment efforts.

To strengthen its services, the nurse-midwifery program collects data from women who have just given birth. The program also cultivates legislative partnering to build the role of nurse-midwives in the state.

Advocates of nurse-midwifery stress its cost-effectiveness. For example, the cesarean section rate for births attended by nurse-midwives is half the rate for physician-delivered births.

Lessons Learned

In terms of systems development, the programs shared several lessons that they learned, including the following:

- A clearly defined vision is essential.
- Unifying approaches and guiding principles enhance planning efforts.
- Systems integration is necessary at all levels. Where possible, complementary state, regional, and local efforts should occur simultaneously.
- Programs should build on existing initiatives.
- Having a core staff to work continuously on systems development is helpful.
- Systems integration is grounded in relationships, which require continuous nurturing.

Parent-Professional Collaboration Models

Opening Doors (Recommended Practices for Home Visiting Integration for Early Intervention)

Richard Roberts, Ph.D.

Opportunities for Parents and Professionals to Understand Strategies for Cross-Cultural Communication

Diane Behl

Randi Malach

Community Profile

Target populations for the two projects described in this workshop were culturally diverse families of children with special health care needs in 15 states across the country.

Community Systems-Building Effort

The two projects discussed in this presentation focused on developing more effective models for family-professional collaboration.

Opening Doors (Recommended Practices for Home Visiting Integration for Early Intervention)

The Opening Doors project at Utah State University involves a consortium of six states (Utah, Washington, Hawaii, Maine, Florida, and Missouri). Looking at 12 communities within these states, the project team studied the integration into each state's overall system of care of services for young children (from birth to 3 years) with special health or educational needs. The ultimate goal was to strengthen family-professional partnerships and services for young children.

Funded for 4 years by the Maternal and Child Health Bureau, Opening Doors sought to define and strengthen recommended-prac-

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tice models for early-intervention home visiting services within the consortium states (and potentially nationwide). In addition, the project team conducted a national survey of home visiting programs identified by each state and a meta-analysis of research literature on home visiting published between 1980 and 1995.

The model is family-centered, comprehensive, and culturally competent. Professionals serve as collaborators, facilitators, and negotiators rather than as expert problem solvers and decision makers.

From the community level through the state and federal levels, vertically and horizontally, family presence and input are crucial for effective service delivery. The parent-professional partnership needs to be equal, with mutually negotiated agreement on goals, needs, and participants. Services need to be coordinated at all levels to eliminate the fragmentation that frustrates families. Finally, family-professional partnerships cannot flourish if providers, institutionally and individually, fail to understand the cultural norms and values that motivate families.

Opening Doors found three consistent priorities among families across the country: easier access to existing services, improved coordination, and additional family supports.

Results from a national survey of current practices indicated that many programs are now including measures to improve collaboration with families, such as

- linking new parents with other families,
- having parents on advisory boards,
- gathering parent input into policies and guidelines, and
- having parents participate in training.

The survey also shed light on factors that prevent many families from using available services. These include

- lack of awareness of the existence of services;
- lack of recognition of the need for services;
- failure to meet eligibility criteria; and

- difficulties with transportation, language, ethnic issues, and other factors.

The survey findings enable professionals working at a community level to look at their programs' strengths and weaknesses, thereby helping them to improve the level of family-professional collaboration.

Opportunities for Parents and Professionals to Understand Strategies for Cross-Cultural Communication

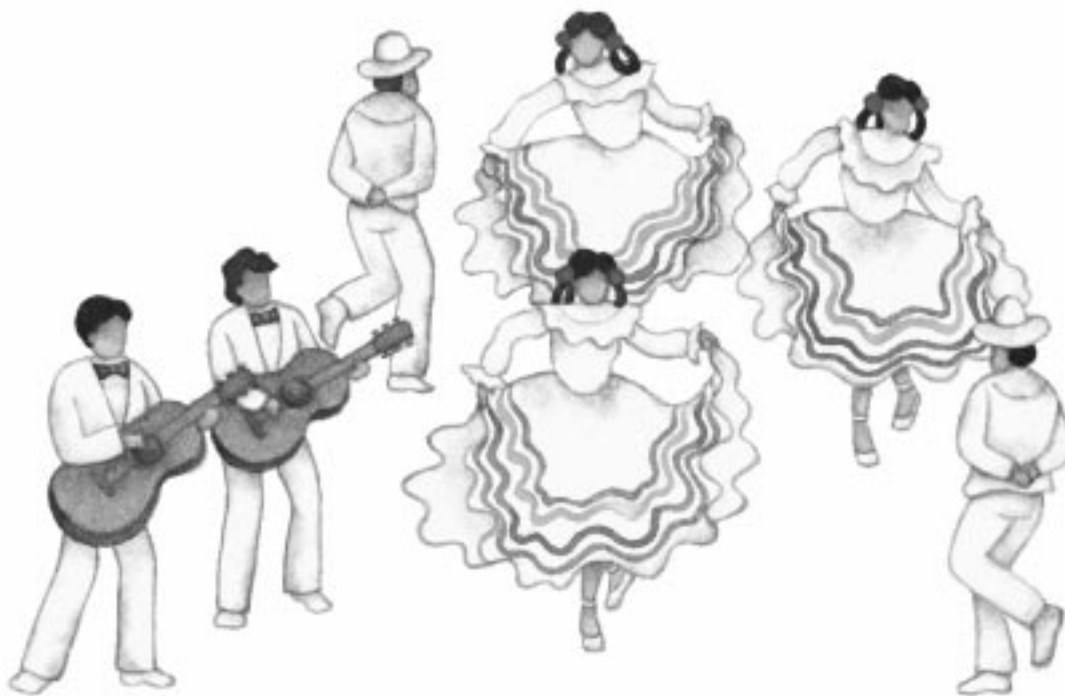
This project, known as OPUS, was funded by the Maternal and Child Health Bureau and conducted by Southwest Communication Resources. OPUS sought to improve services for culturally and ethnically diverse families whose children have special health care needs by identifying factors that inhibit or enhance effective service delivery. Four groups were targeted: African Americans, Native Americans, Asians, and Hispanics/Latinos.

In New Mexico, OPUS established a parent-professional task force that included parents from different cultural groups, direct service providers, administrators, and state-level policy planners. Parents participated in every aspect of the project and were paid for their involvement.

Task force members shared many attitudes and values about cultural competency and awareness. However, they were surprised by the difficulties they encountered in grappling with cultural and ethnic issues.

In the other key part of the project, OPUS conducted focus groups in California, Colorado, Louisiana, Washington, DC/Maryland, Michigan, Ohio, Washington, and Wisconsin. By listening intently, without attempting to defend or explain, the OPUS team gained several insights into parents' perspectives.

- Providers look for weaknesses and deficits and do not recognize the strengths of families and their culture.
- Providers wonder why families do not move closer to services, failing to recognize



the importance of the cultural environment to overall family wellness.

- Although many interpreters can translate a language, they cannot do the “cultural interpretation” necessary to explain a family’s values and motivations.
- Cultural differences, including methods of communication and attitudes toward time, can make collaboration difficult if they are not understood by providers.
- Systems need to be integrated and culturally responsive to a family’s priorities.
- Confidentiality by providers is absolutely essential to gain families’ trust and participation.

The focus groups also discussed specific ways that providers could improve their level of collaboration with families.

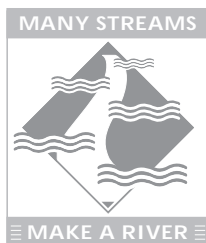
- A state-level interpreter resource bank could help agencies to deliver more timely translation services.
- Providers at all levels, including those whose primary work is in policy

development, should have direct contact with families.

- State and local agencies and educational institutions should collaborate to develop and deliver cultural training to providers.
- Families and providers should learn together and share each other’s perspectives.

To facilitate provider training, OPUS developed educational packets in small segments. Instead of having to digest a huge manual, providers can study individual topics in small blocks of time. OPUS also developed training posters that providers can display in their offices.

In working with target populations in states across the country, the OPUS project team found that families of children with special health needs are eager to collaborate with service providers. Successful partnerships, however, require an understanding and appreciation of cultural differences. ▲



National Conference on Community
Systems-Building and Services Integration

Part III

Appendices



Agenda

Sunday September 14, 1997

9:00 – 12:00 pm	Exhibit Setup	Regency Room
10:30 – 11:30 am	Facilitators' Meeting	
11:00 – 6:00 pm	Registration	Plaza Ballroom Foyer
12:00 – 6:00 pm	Exhibits Open	Regency Room
1:00 pm	Opening Plenary Session	Plaza Ballroom
	Welcome	
	<i>Phyllis E. Stubbs-Wynn, MD</i> Maternal and Child Health Bureau Health Resources and Services Administration	
	<i>Audrey H. Nora, MD, MPH</i> , Assistant Surgeon General Maternal and Child Health Bureau Associate Administrator, Health Resources and Services Administration	
1:15 pm	Opening Speaker	
	<i>John P. Kretzmann, PhD</i> Co-Director, The Asset-Based Community Development Institute Northwestern University	
2:00 pm	Plenary Reaction Panel	
	Panel Moderator: <i>Martin J. Blank</i> , Director of Community Collaboration, Institute for Educational Leadership	
	Panel Members:	
	<i>Florene Poyadue, MA</i> , National Projects Director Parents Helping Parents, Inc.	
	<i>The Reverend Melvin Tuggle</i> , President Clergy United for Renewal of East Baltimore (CURE)	
	<i>Beth Scalco, MSW</i> , Director, HIV/AIDS Programs Louisiana State University Medical Center	
	<i>Maria Gomez, BSN, RN, MPH</i> , Executive Director Mary's Center for Maternal and Child Care, Inc.	

3:00 pm	Break	
3:15 pm	Networking: Ice Breaker <i>Martin J. Blank</i> , Director of Community Collaboration Institute for Educational Leadership <i>Mary Skelton Roberts</i> , Senior Associate Program for Community Problem Solving	
4:45 pm	Reception	<i>Atrium/Gazebo</i>

Monday, September 15, 1997

7:15 – 4:30 pm	Exhibits Open	<i>Regency Room</i>
7:15 – 8:30 am	Networking Breakfast “ What Have We Learned... ” — a dialogue among participants sharing lessons learned on program successes, strategies and resources <i>Martin J. Blank</i> , Director of Community Collaboration Institute for Educational Leadership <i>Mary Skelton Roberts</i> , Senior Associate Program for Community Problem Solving	<i>Plaza Ballroom</i>
8:45 am	Concurrent Sessions I: Showcase of Innovative Programs <i>(see attached Concurrent Session Listing for session descriptions and locations)</i>	
10:15 am	Break	
10:30 am	Concurrent Sessions II: Technical Assistance Workshops <i>(see attached Concurrent Session Listing for session descriptions and locations)</i>	
12:15 pm	Lunch	<i>Plaza Ballroom</i>

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12:45 pm

Luncheon Program

Moderator:

David Heppel, MD, Director, DMICAH
Maternal and Child Health Bureau

Remarks:

Claude Earl Fox, MD, Acting Administrator
Health Resources and Services Administration

Introduction of Speaker:

Anne Harrison-Clark, Director External Affairs
The DELTA Project

Luncheon Speaker:

The Honorable Donald M. Fraser, former Mayor of
Minneapolis, Minnesota

1:15 pm

Networking Session: “If I Could Have...” — a
dialogue among participants on what networking
and communication support they need and would
like to have to improve their programs

Plaza Ballroom

Martin J. Blank, Director of Community Collaboration
Institute for Educational Leadership

Mary Skelton Roberts, Senior Associate
Program for Community Problem Solving

2:00 pm

Break

2:15 pm

**Concurrent Sessions III: Showcase of
Innovative Programs** (see attached *Concurrent
Session Listing* for session descriptions and locations)

3:30 pm

Break

3:40 pm

Closing Plenary Session

Plaza Ballroom

Moderator:

Alexander F. Ross, ScD, HIV/AIDS Bureau
Health Resources and Services Administration

Synthesis of Networking Sessions

Martin J. Blank, Director of Community Collaboration
Institute for Educational Leadership

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Mary Skelton Roberts, Senior Associate
Program for Community Problem Solving

Closing Speaker

The Honorable Sharifa Wilson, Vice Mayor
East Palo Alto, CA

4:30 pm Adjournment

Concurrent Sessions I: Showcase of Innovative Programs

Monday, September 15, 1997 • 8:45 a.m.–10:15 a.m.

Hale Empowerment and Revitalization Organization (HERO), Hale County, Alabama

Presenter: *The Honorable William Ryan* and *Richard Rhone*, EdD, Director, Family Resource Center

Facilitator: *Anne Harrison-Clarke*

Room: Parklawn

National Native American AIDS Prevention Center, Oakland, California

Presenter: *Paul Bouey*, Project Director

Facilitator: *Alexander Ross*

Room: Presidential I

Hillsborough County Health Care Plan, Tampa, Florida

Presenter: *Cretta Johnson*, Director

Facilitator: *Regan Crump*

Room: Woodmont

Local INvestment Commission (LINC), Kansas City, Missouri

Presenter: *Tim Decker*, Neighborhood Development Coordinator

Facilitator: *Jane Coury*

Room: Conference Theatre

Rural Partnership for Children, Omaha, Nebraska

Presenter: *Kim Engel*, *Sandy Roes*, Co-Project Directors for Childhood Advocacy

Facilitator: *Latricia Robertson*

Room: Twinbrook

Growing Into Life Task Force, Aiken, South Carolina

Presenter: *Karen Papouchado*, Coordinator, Barbara Strack, Coordinator

Facilitator: *Mechelle Abernathy*

Room: Halpine

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***Note: The following presentations will be repeated at Concurrent Session III from 2:15 p.m. – 3:30 p.m.**

***Healthy Families Partnership, Hampton, Virginia**

Presenter: *Teresa Woodard, RN*, Healthy Start Director and *Debbie Russell*, Prevention Programs Director

Facilitator: *Joseph Zogby, MSW*

Room: Rockville

***Group Presentation—Serving Children with Special Health Care Needs and Their Families
Washington State Systems Building and Services Integration Initiatives**

Facilitator: *Patricia McGill Smith*

Room: Presidential II

- *Interactive Video-Teleconferencing (IVTC) in a Community Organization Care Network, Yakima, Washington*
Presenters: *Jo Ann Jennings*, Director of Child Health Services and *Karen Sizemore*, Outreach Clinic Coordinator, Washington State Children's Health Access Project
- *Washington State Community Health Care Project, Lakewood, Washington*
Presenter: *Heather Hebdon*, Project Coordinator

***Group Presentation—Enhancing Access and Capacity through Non-Traditional Providers
Wisconsin State Systems Building and Services Integration Initiatives**

Facilitator: *Jerry Hood* and *Irene Sandvold*

Room: Montrose

- *Wisconsin State Systems Development Initiative, Madison*
Presenter: *Colleen Cantlon*, SSDI Contract Administrator
- *Marquette University College of Nursing Nurse-Midwifery Program, Milwaukee*
Presenter: *Leona VandeVusse*, Program Director
- *53212 Perinatal Partnership, Milwaukee*
Presenter: *Bill Solberg*, Project Director
- *Wisconsin Area Health Education Center (AHEC), Madison*
Presenter: *Susan Tillema*, SSDI Project Coordinator

***Group Presentation—Parent/Professional Collaboration Models in Systems Building and Services Integration**

Facilitator: *Diana Denboba*

Room: Randolph

- *Opening Doors, Logan, Utah*
Presenter: *Richard Roberts*, Project Director
- *Opportunities for Parents and Professionals to Understand Strategies for Cross-Cultural Communication, Bernalillo, New Mexico*
Presenter: *Randi Malach*, Project Director

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Concurrent Sessions II: Technical Assistance Workshops

Monday, September 15, 1997 • 10:30 a.m.–12:15 p.m.

Asset-Based Community Development Institute, Northwestern University, Chicago, Illinois

Presenter: *Byron White*

Facilitator: *Sherilyn Pruitt*

Room: Conference Theatre

Parent Training Program: Selecting the Best Program and Staff Training for Your Community, Center for the Improvement of Child Caring, Studio City, California

Presenter: *Kerby Alvy, PhD*, Executive Director

Facilitator: *Jane Coury*

Room: Montrose

Coalition for Healthier Cities and Communities

Presenter: *William Powanda*, Communications Chair, Coalition for Healthier Cities and Communities; Vice President, Griffin Hospital, Derby, Connecticut

Facilitator: *Regan Crump*

Room: Parklawn

The DELTA Project, Bethesda, Maryland

Presenter: *Anne Harrison-Clark*, Executive Director, External Affairs

Facilitator: *Bea Miller*

Room: Rockville

Harrison Institute for Public Law, Georgetown University Law Center, Washington, DC

Presenter: *John Pomeranz, JD, LL.M.*, Adjunct Professor/Staff Attorney

Facilitator: *Melva Tuggle Owens*

Room: Halpine

Health Systems Research, Inc., Washington, DC

Presenter: *Judith Gallagher, RN, EdM, MPA*, Senior Program Consultant and Ian Hill MSW, MPA, Associate Director

Facilitator: *Joseph Zogby, MSW*

Room: Twinbrook

Together We Can Initiative, Washington, DC

Presenter: *Martin Blank*, Managing Partner

Facilitator: *Claudia Morris*

Room: Presidential II

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**National Training and Technical Assistance Center, Office of Juvenile Justice and
Delinquency Prevention, University of Utah**

Presenter: *Joyce Thomas, RN, MPH*, Executive Director, Center for Child Protection and Family
Support

Facilitator: *John McGovern*

Room: Presidential I

Replication: Increasing the Return on Social Investment, Philadelphia, Pennsylvania

Presenter: *Narcisa Polonio, EdD*, Chief Operating Officer, Replication and Program Strategies, Inc.

Facilitator: *Mechelle Abernathy*

Room: Woodmont

**Maternal and Child Health National Center for Cultural Competence, Georgetown University
Child Development Center, Washington, DC**

Presenter: *Tawara Taylor*, Assistant Director

Facilitator: *Diana Denboba*

Room: Randolph

Concurrent Sessions III: Showcase of Innovative Programs

Monday, September 15, 1997 • 2:15 p.m.– 3:30 p.m.

Baltimore City Healthy Start Program, Baltimore, Maryland

Presenter: *Thomas Coyle*, Project Director

Facilitator: *John McGovern*

Room: Twinbrook

Mercy Children's Health Outreach Project, Mercy Medical Center, Baltimore, Maryland

Presenter: *Catherine Kelly, CRNP, MPH*, Director Community Health Programs

Facilitator: *Diane Dimperio*

Room: Presidential II

Michigan Public Health Institute, Okemos, Michigan

Presenter: *Christina Patterson, MHS*, Associate for Program Policy and Research and *Donna
Strugar-Fritsch*, Director of Planning

Facilitator: *Jane Coury*

Room: Halpine

Ready-2-Work, Minneapolis, Minnesota

Presenter: *Kris Schoeller*, Family Transition Resource Coordinator

Facilitator: *Melva Tuggle Owens*

Room: Randolph

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Comprehensive Community Health and Services Program of Project Vida, El Paso, Texas

Presenter: *Bill Schlesinger*, Co-Director

Facilitator: *Sherilyn Pruitt*

Room: Parklawn

Vermont Comprehensive Community-Based System of Care for Children and Adolescents, Burlington, Vermont

Presenter: *Paula Duncan, MD*, Project Director

Facilitator: *Jerry Hood*

Room: Conference Theatre

***Note: The following presentations are repeated from Concurrent Session I at 8:45 – 10:15 a.m.**

***Healthy Families Partnership, Hampton, Virginia**

Presenter: *Teresa Woodard, RN*, Healthy Start Director and *Debbie Russell*, Prevention Programs Director

Facilitator: *Joseph Zogby, MSW*

Room: Rockville

***Group Presentation—Serving Children with Special Health Care Needs and Their Families—Washington State Systems Building and Services Integration Initiatives**

Facilitator: *Patricia McGill Smith*

Room: Presidential I

- *Interactive Video-Teleconferencing (IVTC) in a Community Organization Care Network, Yakima, Washington*
Presenters: *Jo Ann Jennings*, Director of Child Health Services and *Karen Sizemore*, Outreach Clinic Coordinator, Washington State Children's Health Access Project
- *Washington State Community Health Care Project, Lakewood, Washington*
Presenter: *Heather Hebdon*, Project Coordinator

Concurrent Sessions III: Showcase of Innovative Programs (Continued)

Monday, September 15, 1997 • 2:15 p.m. – 3:30 p.m.

***Group Presentation-Enhancing Access and Capacity through Non-Traditional Providers Wisconsin State Systems Building and Services Integration Initiatives**

Facilitator: *Irene Sandvold*

Room: Montrose

- *Wisconsin State Systems Development Initiative, Madison*
Presenter: *Colleen Cantlon*, SSDI Contract Administrator
- *Marquette University College of Nursing Nurse-Midwifery Program, Milwaukee*
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- *Wisconsin Area Health Education Center (AHEC), Madison*

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***Group Presentation-Parent/Professional Collaboration Models in Systems Building and Services Integration**

Facilitator: *Diana Denboba*

Room: Woodmont

- *Opening Doors, Logan, Utah*

Presenter: *Richard Roberts*, Project Director

- *Opportunities for Parents and Professionals to Understand Strategies for Cross-Cultural Communication, Bernalillo, New Mexico*

Presenter: *Randi Malach*, Project Director

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